



**COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH**

**PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION**

**QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT
CALENDAR YEAR 2014**

And

**QUALITY IMPROVEMENT WORK PLAN
CALENDAR YEAR 2015**

**Marvin J. Southard, D.S.W.
Director**

March 2015

COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU

QUALITY IMPROVEMENT DIVISION

QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT – CALENDAR YEAR 2014 AND QUALITY IMPROVEMENT WORK PLAN – CALENDAR YEAR 2015



Executive Summary March 2015

Marvin J. Southard, D.S.W.
Director

The County of Los Angeles Department of Mental Health (LACDMH) Quality Improvement Annual Work Plan is organized into six (6) major domains, which include: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, and Provider Appeals. Each domain is designed to address service needs and the quality of services provided. The Quality Improvement Program is dedicated to fostering consumer focused, culturally competent services and improving access to underserved populations.

The County of Los Angeles is the most populated county in the nation with an estimated population of 10,019,362 in CY 2013. The estimated distribution by ethnicity in the major designated ethnic categories is: Latinos representing 48.2%, Whites 28.5%, Asian and Pacific Islanders 14.6%, African Americans 8.5%, and Native Americans representing 0.2%. During FY 2013-2014, the Department and its contracted and directly operated agencies provided a full array of mental health services to approximately 265,000 children and youth with Serious Emotional Disturbance (SED) and adults and older adults with Serious Mental Illness (SMI). The work plan goals focus on the outpatient programs that served 196,002 persons of all age groups in each of the eight (8) Service Areas and countywide.

This Quality Improvement Work Plan Evaluation Report details the progress LACDMH has made with respect to the 2014 Annual Work Plan Goals. The report presents an analysis of estimated unmet needs for populations countywide as well as for individual Service Areas. Penetration rates are used to analyze service utilization and to measure disparity. The California Health Interview Survey (CHIS) estimated prevalence rates were adopted in 2013 to estimate the countywide and Service Area prevalence rates for persons with SED and SMI. The use of trending analysis is another means to further understand and assess target population needs. As such, trending data is included in this report as appropriate for selected performance measures. The expansion of services with healthcare reform is significant for LACDMH requiring integration of physical health, mental health, and substance abuse services. Service delivery capacity work plan goals for 2015 are based on population living at or below 138% Federal Poverty Level (FPL) population to include services to newly eligible under the Medicaid Expansion as of January 2014.

The 2015 Quality Improvement Work Plan Goals are set by the PSB-QI Division under the authorization of the DMH Executive Management Team and in collaboration with DMH Bureaus and Divisions including: Emergency Outreach Bureau, Patients' Rights Office, Office of the Medical Director, ACCESS Center, the Mental Health Services Act (MHSA) Implementation and Outcomes Division, Office of the Director, Community and Government Relations Division, Managed Care Division, Provider Support Organization and Service Area Quality Improvement Committees, who have all contributed to this report.

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THE ABOVE DOCUMENTS ARE AVAILABLE ONLINE AT:
[HTTP://PSBQI.DMH.LACOUNTY.GOV/QI.HTM](http://psbqi.dmh.lacounty.gov/qi.htm)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

**QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR
CALENDAR YEAR 2014**

and

QUALITY IMPROVEMENT WORK PLAN FOR 2015

In partnering with consumers, families and communities to create culturally competent opportunities for Hope, Wellness and Recovery, the County of Los Angeles Department of Mental Health (LACDMH) is committed to serving, improving and making a difference in the lives of Los Angeles County residents diagnosed with mental illness.

The Affordable Care Act National Strategies for Quality Improvement in Health Care guide our efforts to achieve the three aims of improving the quality of care, improving the health of consumers, and providing affordable care. Through ongoing innovation we strive for an integrated model of healthcare that encompasses mental health, physical health, and substance abuse services. LACDMH is working to design and implement a next-generation behavioral health service delivery system, which provides an integrated array of high-quality, recovery-focused behavioral health services achieving the triple aim. We embrace the cultural diversity of the communities we serve and we recognize that our highly diverse and interconnected set of communities each has unique cultures, strengths, challenges, and behavioral health needs.

The LACDMH Quality Improvement Work Plan Goals are specifically focused on Service Delivery Capacity and Accessibility of Services in order to eliminate disparities; increasing Beneficiary Satisfaction; improving Clinical Care and Continuity of Care; and the monitoring of Provider Appeals.

This report is completed in compliance with Local Mental Health Plan (LMHP) reporting requirements of the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning Quality Improvement.

SECTION 1

QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Quality Improvement Program Structure

The Program Support Bureau (PSB), Quality Improvement Division (QID) is under the administration and direction of the PSB Deputy Director. PSB-QID shares responsibility with providers to maintain and improve the quality of service and the delivery infrastructure. QID establishes annual work plan goals, monitors departmental activities for effectiveness, and conducts processes for continuous improvement of services. The structure and process of the LACDMH QI Program are outlined in the Department's Policy and Procedure 105.1, Quality Improvement Program Policy. QID works to ensure that the quality and appropriateness of care delivered to consumers meets or exceeds local, State, and Federal service standards. The QI Program is organized and implemented in support of an organizational culture of continuous quality improvement that fosters wellness and recovery; reduces disparities; promotes consumer and family involvement; improves cultural competency; and integrates the treatment of mental health and substance use disorders with physical healthcare.

PSB-QID includes the following three (3) Units: the Quality Improvement (QI) and Data-Geographic Information System (GIS) Unit, the Under Represented Ethnic Populations (UREP)/Innovations (INN) Unit, and the Cultural Competency Unit (CCU). The QI-Data GIS Unit is responsible for the collection, analysis, and reporting of LACDMH demographic and clinical data. The QI-Data GIS Unit conducts assessments of the Department's geographic distribution of mental health services. The UREP/INN Unit has responsibility for implementing one-time funded projects within our system of care to build capacity and increase access for Under Represented Ethnic populations, specifically the African/African American, American Indian/Alaska Native, Asian Pacific Islander, Eastern-European/Middle Eastern, and Latino communities. The UREP/INN Unit also implements the Community-Designed Integrated Service Management (ISM) Model which promotes the establishment of networks of care that include formal providers, non-traditional healers, and community-based organizations to integrate physical healthcare, mental health care, and substance use treatment for the five UREP groups. CCU, managed by the LACDMH Ethnic Services Manager (ESM), promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations. CCU provides technical assistance and training necessary to integrate cultural competency into departmental operations and works to implement the Cultural Competency Plan.

The QI Work Plan includes areas of performance measurement, monitoring, and management regarding service delivery capacity; timeliness, accessibility, and quality of services; cultural competency; and consumer and family satisfaction.

The data collected is analyzed and used for decision making, monitoring change, and for performance management to improve services and the quality of care. Departmental Performance Improvement Projects (PIPs) are conducted to ensure that selected administrative and clinical processes are studied to improve performance outcomes. The QI Division collaborates and coordinates with many of the Department's Bureaus, Divisions and Units to conduct related QI activities including the following: Quality Assurance Division; ACCESS Center; Patients' Rights Office; Office of Strategies for Total Accountability and Total Success (STATS) and Informatics; Office of the Medical Director (OMD); Mental Health Services Act (MHSA) Implementation Outcomes Unit; Emergency Outreach Bureau (EOB); Service Area QI Committees and the multidisciplinary PIP Teams.

The departmental Countywide Quality Improvement Council (QIC) is chaired by the PSB-QID Mental Health Clinical Program Manager. It is Co-Chaired by a Regional Medical Director from OMD. The PSB-QID Mental Health Clinical Program Manager also participates on the Southern California QIC, the Statewide QIC, the LACDMH STATS, the Clinical Policy Committee, and the Executive Dashboard. The supervisor of the CCU serves as the LACDMH Ethnic Services Manager and is a standing member of the departmental Countywide QIC, the departmental Countywide Cultural Competency Committee (CCC), and the Cultural Competency, Equity, and Social Justice Committee (CCESJC).

The QI Program acts in coordination with the service delivery system. The departmental Countywide QIC meets monthly and includes standing representation from each of the eight (8) Services Areas, departmental programs and divisions, and other stakeholders. All Service Areas have their own Service Area Quality Improvement Committee (SA QIC) meetings. Each SA QIC has a Chairperson representing Directly Operated Providers and most have a Co-Chairperson who represents Contract Providers. The SA QIC Chairperson and Co-Chairperson are representative members of the departmental Countywide QIC. The QI Handbook is designed to be a reference for the QI structure and process providing guidelines for the functions and responsibilities of QIC members at all levels of participation.

At the provider level, all Directly Operated and Contracted Providers participate in their own Organizational QIC. In order to ensure that the QIC communication feedback loop is complete, all SA Organizational Providers are required to participate in their local SA QIC. This constitutes a structure that supports effective communication between Providers and Service Area QICs, up to the departmental QIC, and back through the system of care. An additional communication loop exists between the SA QIC Chairperson and/or Co-Chairpersons and the respective Service Area District Chiefs and Service Area Advisory Committee (SAAC). The SAACs are comprised of consumers, family members, providers and LACDMH staff. The SAACs provide valuable information for program planning and opportunities for program and service improvement. SAACs are a centralized venue for consumers and family members to participate.

Cultural Competency Committee (CCC)

The CCC serves as an advisory group for the infusion of cultural competency in all LACDMH operations, service planning, delivery and evaluation. Administratively, the CCC is housed within the Program Support Bureau – QID Cultural Competency Unit (CCU). Comprised of seventy-seven (77) members, the CCC membership includes the cultural perspectives of consumers, family members, advocates, Directly Operated providers, Contract providers, and community-based organizations. In addition to promoting participation of consumers, family members, and community members, the CCC considers the expertise from the SAs, clinical programs, administrative programs, front line staff, and management to be essential for the mission of the CCC as well as the impact that the Committee hopes to have on our current system of care.

The membership of the CCC is culturally and linguistically diverse. Fourteen (14) ethnic/racial/biracial/multiracial groups are represented within the CCC: African American, Anglo European, American Indian, Armenian, Asian, Chinese, Eastern European, German, Korean, Vietnamese, and White/Caucasian. The biracial/multiracial membership of the CCC includes: American Indian/Chicano, Asian/Indian, Cahuilla/Caucasian, Chicano, Iranian American, Japanese American, Latino/Chinese, Mexican American, and Spaniard/Latino/American Indian.] Additionally, the following thirteen (13) languages are represented in the CCC membership: Armenian, Cahuilla, Cantonese, English, Farsi, French, German, Hindi, Korean, Spanish, Swahili, Telugu, and Vietnamese.

The overarching goal of the CCC is to increase cultural awareness, sensitivity and responsiveness in the County of Los Angeles Department of Mental Health's response to the needs of diverse cultural populations to foster hope, wellness, and recovery in our communities. All roles, functions, and workgroups of the CCC are based on our strong commitment to further the Department's progress in the provision of culturally and linguistically competent services.

The CCC meets once a month and is led by two Co-Chairs elected annually by members of the Committee. The LACDMH Ethnic Services Manager (ESM) is a member of the departmental Countywide QIC and the CCC. The LACDMH ESM is also the supervisor for the Program Support Bureau-Cultural Competency Unit (PSB-CCU). This structure facilitates communication and collaboration for attaining the goals as set forth in the departmental QI Work Plan and the Cultural Competency Plan to reduce disparities, increase capacity, and improve the quality and accessibility of services. Additionally, relevant CCC decisions and activities are reported to the membership at each departmental QIC meeting.

At the end of each Calendar Year (CY), the Committee holds an annual retreat to review accomplishments, vote on cultural competency objectives to be undertaken for the next year, and reinforce the collaborative team atmosphere

among the Committee members. For CY 2014, the Committee formed four (4) on-going workgroups and one (1) ad-hoc workgroup. These include the following:

- 1) The California Reducing Disparities Project (CRDP) Alignment Workgroup
- 2) The Data Workgroup
- 3) The Outreach and Presentations Workgroup
- 4) The Training Workgroup
- 5) The Vision, Mission and Goals Workgroup was also formed to function on as-needed basis.

1) The CRDP Alignment Workgroup: The goal of this workgroup is to raise awareness and increase knowledge about the five CRDP Reports and PSB-CCU's CRDP Recommendation Matrix within LACDMH and diverse community-based forums. Implemented in September 2014, this workgroup met twice to discuss the content of the CRDP Reports and brainstorm on potential project ideas. The CCC approved the continuation of this workgroup in CY 2015. Project ideas include the following: Engaging the CRDP authors with the CCC, develop workgroup core principles that support the Department's Health Neighborhood Initiative, and support the implementation of CRDP recommendations.

2) The Data Workgroup: The goal of this workgroup is to develop presentations to be delivered at the Service Area Advisory Councils (SAACs) meetings highlighting culture-related data collection practices by County organizations and LACDMH in order to orient these Committees to the relevance of data collection and utilization.

A secondary goal of this workgroup is to develop a data matrix recording demographic variables related to the six (6) PEI Identified Priority Populations formulated by the State. These include:

- Underserved Cultural Populations
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children/Youth in Stressed Families
- Trauma-exposed
- Children at Risk for School Failure
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

Accomplishments include:

Development of a PowerPoint presentation titled "Using data to identify community cultural needs." Intended for SAAC audiences, this presentation highlights County organizations that track culture-related data, LACDMH data reports, the importance and relevance of data collection and utilization, and how to implement data collection projects. The PowerPoint presentation was presented to the CCC for approval in November 2014. The CCC approved the continuation of this workgroup in CY 2015.

- 3) Outreach and Presentations Workgroup: The goal of this workgroup is to increase visibility and awareness of the PSB-CCU and the CCC through Outreach and Presentations to various departmental venues in all Service Areas, such as the SAACs. By disseminating culturally relevant information at the Service Areas, the Outreach and Presentations Workgroup aims to accomplish the following: Learn about the cultural competency needs of the different Service Areas and establish a feedback loop that will provide relevant information regarding the cultural needs of each Service Area.

Accomplishments include:

- Collaborating with the Data Workgroup in the development of SAAC PowerPoint presentation
- Marketing CCC presentations at the SAACs
- Recruitment of SA liaisons to connect the CCC Workgroups with the SAAC Co-Chairs for purposes of scheduling presentations

- 4) The Training Workgroup: The goal of this workgroup is to promote training/education opportunities that address, promote, and enhance cultural competency within our system of care.

Accomplishments include the following:

- Providing training announcements and training registration forms at diverse LACDMH meetings.

- 5) Vision, Mission and Goals Workgroup: This workgroup functions as the ad-hoc workgroup of the CCC. The goal of this workgroup is to develop CCC-related writing and documentation related to the Committee's vision, mission and goals.

Accomplishments include:

- Completion of the CCC's mission statement revision in March 2014.
- The revised mission statement was approved by the CCC.
- The revised mission statement reads: "Increase cultural awareness, sensitivity and responsiveness in the County of Los Angeles Department of Mental Health's response to the needs of diverse cultural populations to foster hope, wellness, and recovery in our communities."

Other CCC general accomplishments include the following:

- Participation and collaboration in the UREP/CCC Leadership Team meetings
- Review and provision of feedback for the MHSA 3-Year Program and Expenditure Plan
- Co-presentation of CCC and UREP recommendations for the MHSA three-year program and expenditure plan at the SLT meeting on January 22, 2014

- Provision of feedback to the Office of Integrated Care on the Department's Health Neighborhoods Initiative

Quality Improvement Program Processes

The purpose of design and implementation of the Countywide QI Program is to ensure an organizational culture of continuous self-monitoring through effective strategies, best practices, and activities at all levels of the system.

PSB-QID works in collaboration with departmental staff to establish annual measureable QI Work Plan goals to evaluate performance management activities. The QI Work Plan Goals are categorized into six (6) domains of State and Federal requirements including the following: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care and Provider Appeals. Evaluation of the work plan goals is published annually in a report and is available online at <http://psbqi.dmh.lacounty.gov/QI.htm>.

PSB-QID is responsible for the formal reporting on annual measurement of consumer perception of satisfaction in six areas namely General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcome, Perception of Functioning and Perception of Social Connectedness. The results are reported annually in the State and County Performance Outcomes Report and are available online at <http://psbqi.dmh.lacounty.gov/QI.htm>.

The PSB-QID team works to engage and support the SA QIC members in QI processes related to the QI Work Plan, specific PIP activities, and other QI projects conducted at the SA level. SA QIC meetings provide a structured forum for the identification of QI opportunities to address challenges and barriers unique to a SA. SA QIC members also support the provider organizational QICs that are focused on internal organization of QI Programs and activities. Organizational QICs conduct internal monitoring to ensure adherence to performance standards related to Quality Assurance and Quality Improvement. This includes activities such as: client record reviews, identifying clinical issues, and client satisfaction surveys.

PSB-QID Unit Program Descriptions

The PSB-QID Under Represented Ethnic Populations (UREP)/Innovation (INN) Unit

One of the cornerstones of the Mental Health Services Act (MHSA) is to empower Under Represented Ethnic Populations (UREP). During the planning phase of MHSA, a UREP Work Group, consisting of 56 culturally diverse mental health professionals and community and consumer advocates, was created to make implementation recommendations to LACDMH. This workgroup met extensively to develop guiding principles and recommendations for LACDMH as well as MHSA services. These recommendations were instrumental in establishing the Department's MHSA values and strategies in working with under represented ethnic groups. In June 2007, the Department established an internal UREP Unit within the Planning, Outreach and Engagement Division to address the ongoing needs of targeted ethnic and cultural groups. The UREP Unit has established subcommittees dedicated to working with the various under represented ethnic populations in order to address their individual needs. These subcommittees are: African/African American; American Indian/Alaska Native; Asian/Pacific Islander; Eastern European/Middle Eastern; Latino; and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ). In March 2012, the UREP/INN Unit was transitioned to the PSB-QID.

Each UREP subcommittee is allotted one-time funding totaling \$100,000 per fiscal year to focus on Community Services and Supports (CSS) based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals were created and submitted via a participatory and consensus-based approach. The following are the projects implemented:

African/African American (AAA) – 1) Resource Mapping Project: Funds were allocated to identify useful community resources, service providers, and agencies in South Los Angeles County where there is a large African/African American (AAA) population. The directory, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers for many categories of various sources. The third reprinting/updated version of this popular resource was released in October 2014, and they are once again in demand. ***2) Community Mental Health Stigma Reduction Project:*** Funds were allocated to community service providers in Los Angeles County to provide tailored community awareness and service strategies to specific, underserved subcultures in the African/African-American community. The focus of this project is to reduce the stigma of mental illness by funding agencies to provide outreach, engagement, training, education, and non-traditional wellness activities. Technological approaches are also being employed, as each agency has targeted a unique subpopulation with unique concerns and needs. The

targeted subpopulations are the LGBTQ community, the Somali community and the Pan-African community. Projects for all three subpopulations are approaching completion of their targeted end date of this six-month project, and each agency has exceeded its service deliverables. **3) Mental Health Informational Brochures:** Brochures will be used to outreach and engage underserved, inappropriately served and hard-to-reach ethnic communities. The purpose is to reduce stigma by identifying common mental health conditions experienced in the AAA community. The brochures will be used to educate and inform these ethnically diverse communities of the benefits of utilizing mental health services, and to provide referrals and contact information. The informational brochure will be translated into two (2) different African languages: Amharic and Somali. The brochure's content has been completed, and negotiations are currently under way for translations and graphics. This phase and the printing phase are expected to be completed by the end of the first quarter of 2015. **4) The Ethiopian Community Mental Health Training and Education (ECMHTE) Project** was a joint effort of the Los Angeles County Department of Mental Health (LACDMH) and the African Communities Public Health Coalition (ACPHC) to reduce the stigma of mental illness, specifically in the Ethiopian community. The purpose was to set a precedent of using culturally appropriate mental health education when working with ethnic communities, and to increase access to culturally appropriate mental health services for people of Ethiopian descent (especially during a mental health crisis). This nine-month project provided training to trusted and selected volunteer community members, referred to as Ethiopian Community Advocates (ECAs), for them to become 'lay-experts' of mental health issues, crisis intervention, and appropriate mental health resources. The ECMHTE Project proved to be very successful, as it exceeded its goals and expectations, gaining national recognition at the Ronald H. Brown African Affairs Series in Washington D.C. in October 2014.

Asian Pacific Islander (API) – The API Consumer and Family Member Training and Employment Program was implemented on August 1, 2014. The goal of this project is to train 15 API consumers and family members to become culturally competent Peer/Family Advocates and Health Navigators. The purpose of this program is to increase the number of culturally competent API Peer/Family Advocates and Health Navigators at mental health agencies that serve the API community. Once the trainings are completed, the consultant will facilitate employment of trainees into mental health agencies that serve the API community. These Peer/Family Advocates and Health Navigators will assist API consumers, especially those with limited English-speaking skills to navigate the public mental health system and access mental health services. For 2014-2015, the API UREP subcommittee is proposing to hire a consultant to launch a Health Education and Outreach program targeting API families with members who suffer from a mental illness. The objective of this project is to increase the family members' awareness about mental illness, increase their knowledge of mental

health resources as well as assistance with accessing culturally and linguistically appropriate treatment. The approval of this project is in process.

Eastern European/Middle Eastern (EE/ME) – The EE/ME UREP subcommittee funded three different capacity building projects for Fiscal Year 2013-2014. For the Armenian and Russian communities, the EE/ME UREP subcommittee funded a televised media campaign, which included the development of 30-second Public Service Announcements (PSAs) that focused on mental health awareness, substance abuse, and domestic violence. The PSAs were aired on local Russian and Armenian television stations within Los Angeles County between August 8, 2014 and November 7, 2014. A total of four (4) Russian and eight (8) Armenian PSAs were aired. As a result of this project, Los Angeles County Department of Mental Health ACCESS Hotline reported that there was an increase in the number of Armenian calls for August 2014 (65 calls), September 2014 (56 calls), and October 2014 (38 calls) compared to less than 10 calls per month between January 1, 2014 to July 31, 2014. For the Persian community, a radio campaign was funded and implemented. Mental Health Radio Talk shows were developed and aired in the local Farsi-speaking radio station. The radio talk shows began to air on July 6, 2014 and continued to air for 22 consecutive weeks. The radio talk shows included the following mental health topics: Anxiety, depression, schizophrenia, acculturation issues, and parenting. This project was completed on November 30, 2014. It was reported by two LACDMH legal entities that specialize in serving the Farsi Speaking community that there was a 55% increase in calls from Farsi speaking community members seeking mental health services during the implementation phase of this project. For the Arabic-speaking community of Los Angeles County, the Community Mental Health Education Project was funded to increase mental health awareness. This project was implemented on December 1, 2014. The Community Mental Health Education Project will provide outreach and engagement services by partnering with faith-based organizations and schools to facilitate mental health community presentations as well as making these materials available by using technological approaches such as web-based informational sites. For FY 2014-2015, the Eastern European and Middle Eastern UREP subcommittee is proposing to launch the following projects: (1) a televised talk show to increase mental health awareness, access, reduce stigma, and increase penetration rates for the Armenian and Russian communities; (2) continuation of the mental health radio talk shows for the Farsi speaking community as they have proven to be effective; twenty one (21) new mental health topics will be identified; and (3) for the Arabic-speaking community, a mental health information and training project is being proposed, but it has not been finalized.

Latino – As an expansion of a previous capacity building project that funded the recruitment, training, and integration of Promotoras de Salud Project Model (Health Promoters) within the Latino Community, the 2013-2014 Latino UREP subcommittee funded a six month research project to measure the effectiveness of the Promotoras Project Model as an outreach and engagement strategy aimed at Latinos within the County of Los Angeles. The research

findings will provide LACDMH with recommendations that will focus on the mental health disparities significantly impacting the Latino Community. For 2014-2015 Latino UREP subcommittee is proposing to launch a Health Neighborhood Mental Health Awareness Outreach Campaign that will disseminate promotional items, which will include mental health information and resources to unserved Latino communities within the County of Los Angeles. In addition, for FY 2014-2015, the Latino UREP subcommittee is proposing to fund a media outreach campaign. The media outreach campaign will consist of LACDMH approved Public Service Announcements (PSAs) that will air in the local Spanish-speaking television and radio stations. The approval of these two projects is currently pending.

American Indian/Alaska Native (AI/AN) – For FY 2013-2014, the AI/AN UREP subcommittee funded the Community Spirit Healers Wellness Project. The project was launched on August 1, 2014 and is in the process of recruiting and hiring five (5) AI/AN community members (called Community Spirit Healers). The Community Spirit Healers will be trained to conduct community trainings and forums, which will focus on mental health awareness and education. For FY 2014-2015, the AI/AN UREP subcommittee funded the American Indian/Alaska Native Mental Health Conference that took place on November 4, 2014 at the California Endowment. The theme for the conference was “Strengthening Native Voices to Build a Healthy Community” and a total of 260 participants attended. A survey was developed and distributed to the conference’s participants, which consisted of five questions, specific to the AI/AN community. The surveys were used to gather valuable information pertaining to the participants’ level of knowledge gained as a result of attending the conference. Data results from the surveys indicated the following: (1) the majority of the conference’s participants (94%) agreed or strongly agreed that the conference made them more aware of mental health issues unique to the AI/AN community; (2) a majority of the conference’s participants (93%) agreed or strongly agreed that the conference improved their ability to recognize when to refer an AI/AN community members for mental health services; and (3) a majority of the conference’s participants (92%) agreed or strongly agreed that they received useful information on mental health resources for mental health treatment for AI/AN community members. Additionally, for FY 14-15, the AI/AN UREP subcommittee will fund the development of PSAs and a media advertisement campaign that will air on the local radio and television channels in Los Angeles County. This media campaign will outreach to the AI/AN community as well as increase mental health awareness throughout the County of Los Angeles. The approval of this project is in process.

Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) - The LGBTQ UREP subcommittee was established on August 27, 2014. As their first project, this subcommittee is currently in the process of launching a LGBTQ survey, which aims to gather data pertaining to mental health clinicians’ level of awareness and sensitivity when providing services for the LGBTQ population. The findings of the surveys will be used to assist the subcommittee to better identify

future capacity building projects targeted for the LGBTQ community. No funding is required for the completion of this survey project. For 2014-2015, the LGBTQ UREP subcommittee will fund two projects, which will focus on mental health awareness, mental health education, and to increase access and penetration rates. One of the projects will focus on developing a culturally competent family advocacy program that will provide peer-to-peer support and family-to-family outreach and education. The second project will provide trainings, technical assistance, and mentoring services to mental health providers as an avenue to increase their knowledge, skills, and ultimately, enhance their clinical skills to better serve the LGBTQ youth population. The approval of these projects is in process.

The PSB-QID Cultural Competency Unit

The Cultural Competency Unit (CCU) is under the direction of PSB-QID. This organizational structure allows for cultural competency to be integrated into PSB-QID roles and responsibilities to systematically improve services and accountability to our consumers, their family members, and the communities we serve. This structure also places the CCU in a position to collaborate with several LACDMH Programs such as the PSB-Under Represented Ethnic Populations (UREP)/Innovation Unit, the Patients' Rights Office (PRO), the Workforce, Education and Training Division (WET), MHSA Implementation and Outcomes Division, and the Service Area (SA) Quality Improvement Committees (QICs). The supervisor for the CCU is also the LACDMH Ethnic Services Manager. This strategy facilitates the administrative oversight of the Cultural Competency Committee (CCC) activities and for the Unit to anchor the Cultural Competence Plan Requirements (CCPR) and the California Reducing Disparities Project (CRDP) Reports as our departmental framework to integrate cultural competency in service planning and delivery. The CCU promotes awareness and utilization of this framework to reduce disparities; combat stigma; promote hope, wellness, recovery and resiliency; and serve our communities with quality care.

Consistent with the CCPR and CRDP recommendations, the CCU engaged in the following activities:

1) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Workgroup

In February 2014, the CCU implemented the LACDMH LGBTQ Workgroup with sixteen (16) members in attendance. Continuous recruitment efforts to bring ethnic/racial, age, gender, and sexual orientation diversity to the Workgroup flourished and membership quickly doubled. At the time of its implementation, the mission statement for this Workgroup was to "Enhance service delivery for LGBTQ communities." For Calendar Year (CY) 2014, the Workgroup identified the following two projects:

1. The development and distribution of an LGBTQ Survey that aimed to collect information on LGBTQ services offered by LACDMH, staff's comfort level in

working with the LGBTQ consumers, and trainings needed to enhance the staff's competency in serving the LGBTQ community effectively. In addition, this workgroup decided to create a glossary of LGBTQ terminology. Once finalized, the glossary will be utilized as an educational tool to inform the LACDMH workforce. The LGBTQ glossary will be disseminated via the Department's electronic news (eNews).

2. The development of a comprehensive LGBTQ resource guide that compiles the existing resources endorsed by agencies that specialize in serving the LGBTQ community in the County of Los Angeles. This resource guide is intended to provide detailed information regarding community resources available for the LGBTQ population.

In September 2014, this Workgroup became the LGBTQ UREP subcommittee. As such, the LGBTQ UREP subcommittee qualifies for funding to develop capacity building projects that will increase access and penetration rates for the LGBTQ population.

2) Service Area Quality Improvement Councils (SA QICs)

In July 2014, the CCU staff assumed the role of liaisons for the SA QICs. In this capacity, each CCU liaison was assigned to specific SA QIC meetings to provide departmental updates related to cultural competency activities, such as the CCPR and CRDP recommendations, the CCC activities, and the UREP subcommittees' capacity building projects. The CCU liaisons also gather information related to cultural competency needs at the Service Area level and communicate this information to the CCU. This practice has established a feedback loop among the SA QICs, the CCU, the UREP Unit and the CCC.

3) Data Collection, Analysis and Reporting of Preferred Language Requests

The CCU collected and analyzed all the preferred language requests reported by LACDMH providers via their Initial Request & Referral Logs for Culture Specific Mental Health Services. The Unit produces monthly and annual summaries of the total requests for preferred threshold and non-threshold languages by Service Area. In accordance with the CCPR, and as a way to improve our service delivery, these reports are utilized to track the language requests from Limited English Proficiency (LEP) consumers at the time they access mental health services.

4) Cultural Competency Trainings

The CCU continues to provide cultural competency presentations for LACDMH employees during the New Employee Orientation. These presentations introduce new employees to the functions of the CCU, the County of Los Angeles Demographics and threshold languages, the Cultural Competence Plan Requirements and the Department's strategies to reduce mental health disparities. Additionally, the CCU is in the process of developing a Statement of Work to implement a Cultural Competency (CC) Web-based Training that will

prepare the LACDMH workforce to appropriately respond to the diverse cultural and linguistic needs of our communities.

5) Implementation of CRDP recommendations

The CCU is responsible for building system awareness of the five (5) CRDP reports and their recommendations to reduce mental health disparities. In this capacity, the CCU provides technical assistance to the UREP Unit in developing capacity building projects that are culturally and linguistically appropriate as well as community driven. Specifically, the CCU assisted the Latino UREP subcommittee to implement a Latino CRDP recommendation for their first capacity building project for 2014. After being informed that the expansion of the Promotores the Salud Model (Health Promoters) is a CRDP recommendation, the subcommittee developed a research project to advance this community-defined practice into a promising practice.

6) Cultural Competence Plan Requirements (CCPR)

Currently, the CCU is actively preparing for the release of the 2015 CCPR by the Department of Health Care Services (DHCS). This process has involved a review of the 2010 LACDMH Cultural Competence Plan to identify sections that need to be updated including new departmental initiatives, programs, policies and procedures. At this time, the CCU has completed the first level of internal revisions. The next steps will involve collaborations between the CCU and LACDMH Programs to gather and align programmatic updates with the CCPR. The CCU will be the lead Unit in conducting all these efforts.

Furthermore, the CCU will collaborate closely with a consultant on the development of a system-wide Cultural Competency Organizational Assessment and a Service Area-based provider survey. These tools will collect information regarding departmental cultural competency practices, service gaps, and lessons learned from our efforts to meet the cultural and linguistic needs of our communities and reduce disparities.

The QI-Data-GIS Unit

The QI-Data-GIS Unit is responsible for compiling system wide information on consumers served and estimating populations in need of mental health services. The QI-Data GIS Unit annually calculates the population estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), and penetration and retention rates by all demographic categories: age, gender, ethnicity and primary language. Trend analysis is conducted on these data to assess fluctuations in service utilization and service delivery capacity. The Prevalence and Penetration Rates are also calculated for the eight (8) Service Areas for dissemination to the respective District Chiefs and Quality Improvement Liaisons for Quality Improvement Projects and Performance Improvement Projects.

Mental Health Service Utilization Rates are calculated by census tracts to conduct spatial analysis to estimate geographic areas in need of services. This information is used to estimate service delivery capacity and set targets for meeting the needs of underserved populations. The QI-Data-GIS Unit provides mapping support to all Divisions in the Department and conducts data analysis of services received by consumers by various geo-political boundaries in the County such as Supervisorial Districts, Service Areas, Health Districts, Medically Underserved Areas, Senate and Congressional boundaries.

The Data GIS Unit maintains and updates the LACDMH Provider Directory of Specialty Mental Health Services (SMHS). The provider directory has information on age groups served, contact information, hours of operation and SMHS provided at each service location to enable consumers and the public to find appropriate mental health services in the County of Los Angeles. The provider directory is disseminated as a hard copy annually to Service Area providers for use by consumers, and their family members, provider staff and other stakeholders.

The Provider Directory is also available on the internet. All information related to providers and their services can be searched via the DMH Service Locator at <http://maps.lacounty.gov/dmhSL/>. Information on the DMH Online Service Locator can be translated into 50 or more languages including the DMH threshold languages. This enables increased access for consumers seeking mental health services in non-English languages.

The QI-Data-GIS Unit is responsible for selecting a random sample for the bi-annual consumer satisfaction survey administration in Short Doyle/Medi-Cal Outpatient Clinics and Day Treatment Programs. The Unit is also responsible for conducting data analysis of the seven (7) domains of perception of consumer satisfaction and preparing a final report. Additionally, the QI-Data-GIS unit provides assistance with survey design and implementation and data support to the Department's Divisions and Bureaus, such as assisting the Office of Consumer Affairs with the annual Peer Survey, the Office of Medical Director with the Seclusions and Restraints Report, and the UREP/INN/CCU with data on disparities for UREP groups.

Summary

The QI Work Plan Evaluation report that follows assesses the goals identified in the LACDMH Quality Improvement Work Plan for Calendar Year 2014. The foundation for this evaluation is presented in the context of population demographics, both Countywide and by Service Area as well as other clinical and consumer satisfaction data, including trending data. Evaluation of the Quality Improvement Work Plan provides a basis for the establishment of goals and objectives for 2015.

SECTION 2

POPULATION NEEDS ASSESSMENT

The County of Los Angeles is the most populated county in the United States (US) with an estimated population of 10,019,362 people in CY 2013. The County consists of 88 legal cities and includes 4,058 square miles of land area. Population density in the County, or the average number of people per square mile, is 2,440 as compared with 244 in the State of California.

Population by Ethnicity in the County of Los Angeles as shown in Fig. 1 is the highest among Latinos at 48.2%, followed by Whites at 28.5%, Asian/Pacific Islanders (API) at 14.6%, African Americans at 8.5%, and Native Americans at 0.2%. This section contains estimated population in CY 2013 for the County of Los Angeles by Ethnicity, Age, and Gender.

Methods

The population and poverty estimates are derived from the American Community Survey conducted by the US Census Bureau. These numbers are further adjusted locally and standardized to annual data provided by the Department of Finance to account for local variations in housing and household income in the County of Los Angeles. Data for Federal Poverty level (FPL) is reported for population living at or below 138% FPL. Data for population living at or below 138% FPL is used to estimate prevalence of mental illness among population eligible for Medi-Cal benefits under the Affordable Care Act (ACA). Population and poverty data is reported by each Service Area (SA), ethnicity, age-group and gender.

Threshold languages for each SA are identified for population enrolled in Medi-Cal and consumers served by LACDMH. Title 9 of the California Code of Regulations (CCR) defines beneficiaries with threshold languages as “the annual numeric identification on a countywide basis and as indicated on the Medi-Cal Eligibility Data System (MEDS), from the 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, in an identified geographic area, whose primary language is other than English, and for whom information and services shall be provided in their primary language.”

Access to services is assessed by calculating Penetration Rates among consumers served in outpatient settings (Mode 15) in Short Doyle/Medi-Cal (SD/MC) facilities in Fiscal Year (FY) 2013-14. The count of consumers served does not include those served in jails, juvenile halls, acute care inpatient settings (both County and Fee for Service (FFS) hospitals,) and FFS outpatient network providers.

The data include the following:

- Estimated Total population and population living at or below 138% Federal Poverty Level (FPL) in CY 2013.
- Estimated Prevalence of Serious Emotional Disturbance (SED) in Children and Youth, and Serious Mental Illness (SMI) in Adults and Older Adults for Total Population and population living at or below 138% FPL.
- Population enrolled in Medi-Cal by ethnicity, age group and gender.
- Estimated prevalence of SED and SMI among population enrolled in Medi-Cal by ethnicity, age group and gender.
- LACDMH threshold languages spoken by population enrolled in Medi-Cal.
- Consumers served in Outpatient Short Doyle/Medi-Cal Facilities by ethnicity, age group, gender, and threshold languages.

These data sets provide a basic foundation for estimating target population needs for mental health services.

Estimated Prevalence Rates for persons with SED and SMI are derived by using Prevalence Rates estimated by the California Health Interview Survey (CHIS) conducted every two years by the University of California, Los Angeles (UCLA).

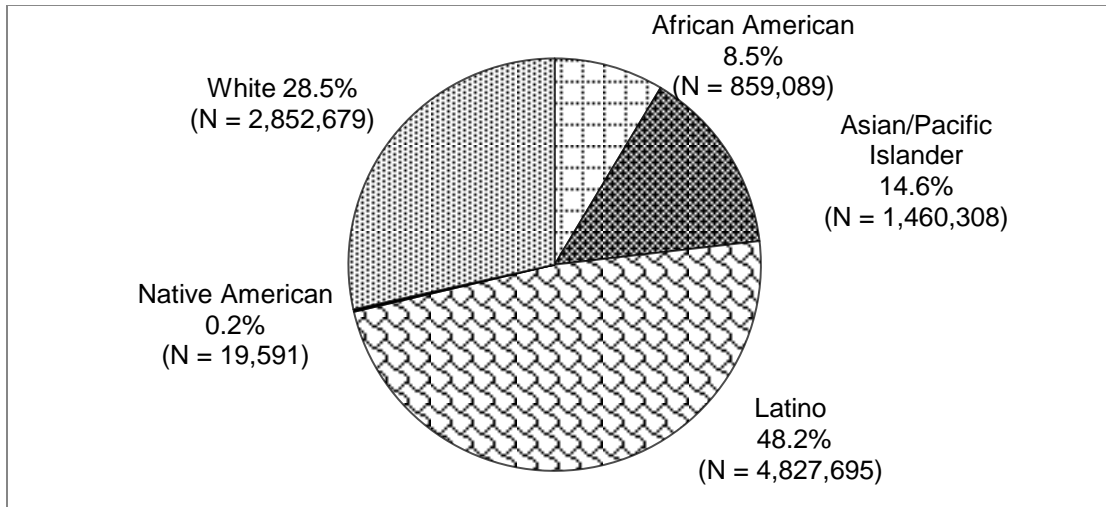
Penetration Rates are derived by applying Prevalence Rates for that ethnic, gender, or age-group to demographic data for consumers served. These data are helpful in understanding the needs of target population and underserved population.

The use of trending analysis is used to understand change in population demographics and performance measures over a five-year period.

As of 2014, QI Work Plan goals related to Access and Penetration Rates have been set for population living at or below 138% FPL to account for expansion of services under the Affordable Care Act (ACA).

Total Population

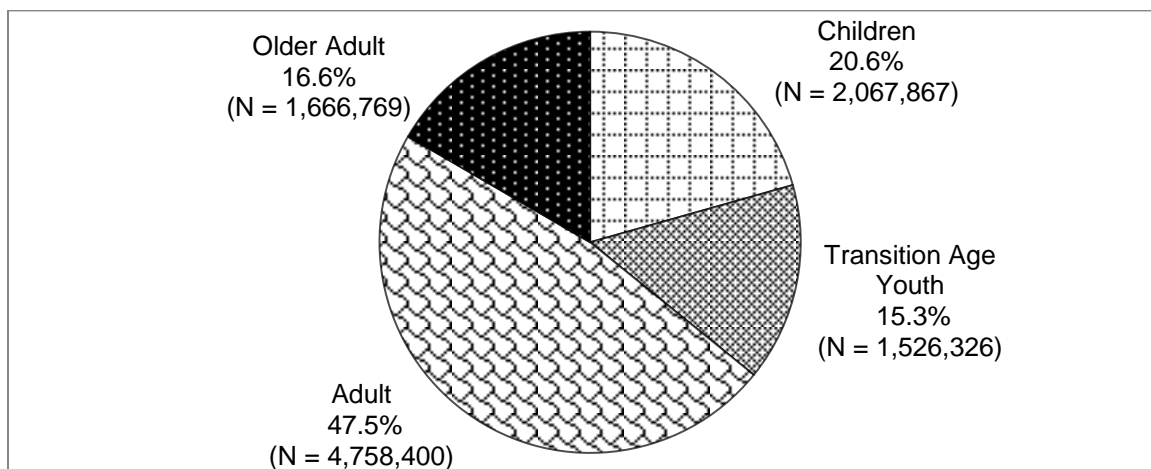
**FIGURE 1: POPULATION BY ETHNICITY
CY 2013 (N = 10,019,362)**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Figure 1 shows population by ethnicity. Latinos are the largest group at 48.2%, followed by Whites at 28.5%, Asian/Pacific Islanders (API) at 14.6%, African Americans at 8.5%, and Native Americans at 0.2%.

**FIGURE 2: POPULATION BY AGE GROUP
CY 2013 (N = 10,019,362)**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Figure 2 shows population by age group. Adults are the largest group at 47.5%, followed by Children at 20.6%, Older Adults at 16.6%, and Transition Age Youth (TAY) at 15.3%.

**TABLE 1: POPULATION BY ETHNICITY AND SERVICE AREA
CY 2013**

Service Area (SA)	African American	Asian / Pacific Islander	Latino	Native American	White	Total
SA 1	62,592	15,467	174,583	1,600	136,696	390,938
Percent	16.0%	4.0%	44.7%	0.41%	35.0%	100.0%
SA 2	76,909	250,948	864,694	3,959	977,222	2,173,732
Percent	3.5%	11.5%	39.8%	0.18%	45.0%	100.0%
SA 3	65,847	508,839	819,204	3,050	380,820	1,777,760
Percent	3.7%	28.6%	46.1%	0.17%	21.4%	100.0%
SA 4	61,196	205,132	588,511	2,134	283,769	1,140,742
Percent	5.4%	18.0%	51.6%	0.19%	24.9%	100.0%
SA 5	37,476	90,278	102,719	976	415,082	646,531
Percent	5.8%	14.0%	15.9%	0.15%	64.2%	100.0%
SA 6	286,384	19,110	695,092	1,490	25,569	1,027,645
Percent	27.9%	1.9%	67.6%	0.14%	2.5%	100.0%
SA 7	39,326	120,583	963,067	2,758	186,082	1,311,816
Percent	3.0%	9.2%	73.4%	0.21%	14.2%	100.0%
SA 8	229,359	249,951	619,825	3,624	447,439	1,550,198
Percent	14.8%	16.1%	40.0%	0.23%	28.9%	100.0%
Total	859,089	1,460,308	4,827,695	19,591	2,852,679	10,019,362
Percent	8.5%	14.6%	48.2%	0.20%	28.5%	100.0%

Note: Bold values represent highest and lowest percent within each ethnic group across Service Areas.
Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Ethnicity

SA 6 at 27.9% has the highest percentage of African Americans as compared to the lowest percentage in SA 7 at 3.0%.

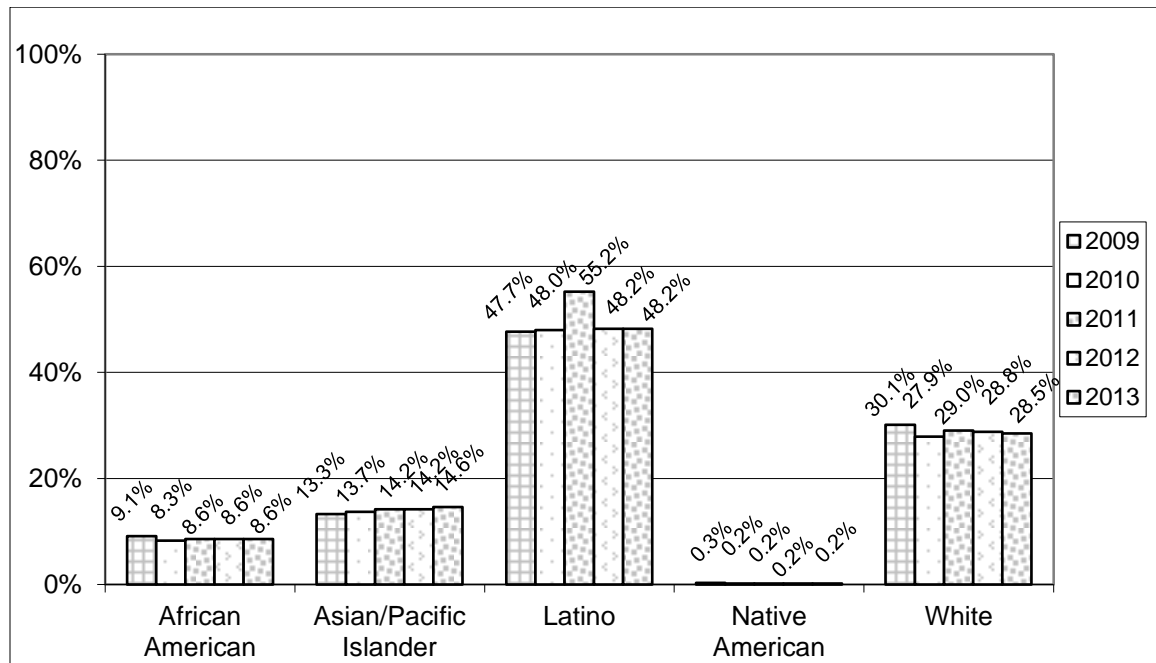
SA 3 at 28.6% has the highest percentage of Asian/Pacific Islanders (API) as compared to the lowest percentage in SA 6 at 1.9%.

SA 7 at 73.4% has the highest percentage of Latinos as compared to the lowest percentage in SA 5 at 15.9%.

SA 1 at 0.41% has the highest percentage of Native Americans as compared to the lowest percentage in SA 6 at 0.14%.

SA 5 at 64.2% has the highest percentage of Whites as compared to the lowest in SA 6 at 2.5%.

**FIGURE 3: POPULATION PERCENT CHANGE BY ETHNICITY
CY 2009-2013**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

The percentage of African Americans in the County has decreased by 0.5 percentage points (pp) over the past five years. African Americans represented 9.1% of the total population in 2009 and represent 8.6% in 2013.

The percentage of Asian/Pacific Islanders (API) in the County has increased by 1.3 pp over the past five years. API represented 13.3% of the total population in 2009 and represent 14.6% in 2013.

The percentage of Latinos in the County has increased by 0.5 pp over the past five years. Latinos represented 47.7% of the total population in 2009 and represent 48.2% in 2013.

The percentage of Native Americans in the County has decreased by 0.1 pp over the past five years. Native Americans represented 0.3% of the total population in 2009 and represent 0.2% in 2013.

The percentage of Whites in the County has decreased by 1.6 pp over the past five years. Whites represented 30.1% of the total population in 2009 and represent 28.5% in 2013.

**TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2013**

Service Area (SA)	Age Group						
	0 - 18	19 - 20	21 - 25	26 - 59	60 - 64	65+	Total
SA1	117,299	15,003	34,258	171,072	17,440	35,866	390,938
Percent	30.0%	3.8%	8.8%	43.8%	4.5%	9.2%	100.0%
SA2	517,058	63,212	160,859	1,054,223	112,723	265,657	2,173,732
Percent	23.8%	2.9%	7.4%	48.5%	5.2%	12.2%	100.0%
SA3	426,551	58,664	138,310	817,943	98,229	238,063	1,777,760
Percent	24.0%	3.3%	7.8%	46.0%	5.5%	13.4%	100.0%
SA4	238,197	28,179	82,399	610,656	51,830	129,481	1,140,742
Percent	20.9%	2.5%	7.2%	53.5%	4.5%	11.4%	100.0%
SA5	111,115	20,379	46,797	335,976	35,930	96,334	646,531
Percent	17.2%	3.2%	7.2%	52.0%	5.6%	14.9%	100.0%
SA6	324,093	39,877	96,028	448,123	36,931	82,593	1,027,645
Percent	31.5%	3.9%	9.3%	43.6%	3.6%	8.0%	100.0%
SA7	370,421	45,877	109,310	586,219	58,163	141,826	1,311,816
Percent	28.2%	3.5%	8.3%	44.7%	4.4%	10.8%	100.0%
SA8	390,590	45,919	113,798	734,188	77,972	187,731	1,550,198
Percent	25.2%	3.0%	7.3%	47.4%	5.0%	12.1%	100.0%
Total	2,495,324	317,110	781,759	4,758,400	489,218	1,177,551	10,019,362
Percent	24.8%	3.2%	7.8%	47.5%	4.9%	11.8%	100.0%

Note: Bold values represent highest and lowest percent within each age group across Service Areas.

Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Age Group

SA 6 at 31.5% has the highest percentage of 0-18 year olds as compared with the lowest percentage in SA 5 at 17.2%.

SA 6 at 3.9% has the highest percentage of 19-20 year olds as compared with the lowest percentage in SA 4 at 2.5%.

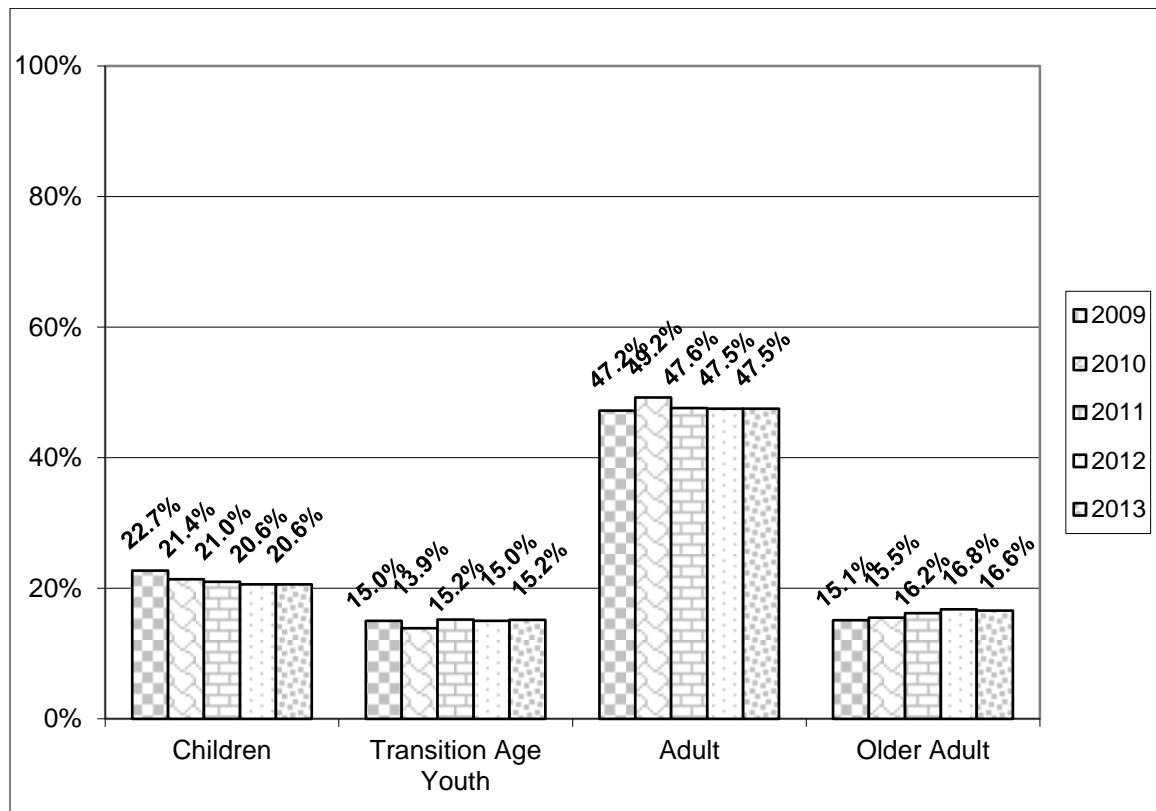
SA 6 at 9.3% has the highest percentage of 21-25 year olds as compared with the lowest percentage in SAs 4 and 5 at 7.2%.

SA 4 at 53.5% has the highest percentage of 26-59 year olds as compared with the lowest percentage in SA 6 at 43.6%.

SA 5 at 5.6% has the highest percentage of 60-64 year olds as compared with the lowest percentage in SA 6 at 3.6%.

SA 5 at 14.9% has the highest percentage of 65+ year olds as compared with the lowest percentage in SA 6 at 8.0%.

**FIGURE 4: POPULATION PERCENT CHANGE BY AGE GROUP
CY 2009-2013**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

The percentage of Children in the County has decreased by 2.1 pp over the past five years. Children represented 22.7% of the total population in 2009 and represent 20.6% in 2013.

The percentage of Transition Age Youth (TAY) in the County has increased by 0.2 pp over the past five years. TAY represented 15.0% of the total population in 2009 and represent 15.2% in 2013.

The percentage of Adults in the County has increased by 0.3 pp over the past five years. Adults represented 47.2% of the total population in 2009 and represent 47.5% in 2013.

The percentage of Older Adults in the County has increased by 1.5 pp over the past five years. Older Adults represented 15.1% of the total population in 2009 and represent 16.6% in 2013.

**TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2013**

Service Area (SA)	Male	Female	Total
SA 1	194,257	196,681	390,938
Percent	49.7%	50.3%	100.0%
SA 2	1,076,178	1,097,554	2,173,732
Percent	49.5%	50.5%	100.0%
SA 3	867,825	909,935	1,777,760
Percent	48.8%	51.2%	100.0%
SA 4	585,309	555,433	1,140,742
Percent	51.3%	48.7%	100.0%
SA 5	312,887	333,644	646,531
Percent	48.4%	51.6%	100.0%
SA 6	500,139	527,506	1,027,645
Percent	48.7%	51.3%	100.0%
SA 7	644,805	667,011	1,311,816
Percent	49.2%	50.8%	100.0%
SA 8	758,333	791,865	1,550,198
Percent	48.9%	51.1%	100.0%
Total	4,939,733	5,079,629	10,019,362
Percent	49.3%	50.7%	100.0%

Note: Bold values represent highest and lowest percent within each gender across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Gender

SA 4 at 51.3% has the highest percentage of Males as compared with the lowest percentage in SA 5 at 48.4%.

SA 5 has the highest percentage of Females at 51.6% as compared with the lowest percentage in SA 4 at 48.7%.

Estimated Population Living at or Below 138% Federal Poverty Level (FPL)

**TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA
CY 2013**

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Total
SA1	28,169	1,878	64,710	461	21,399	116,617
Percent	24.2%	1.6%	55.5%	0.40%	18.3%	100.0%
SA2	16,857	28,976	312,510	626	141,537	500,506
Percent	3.4%	5.8%	62.4%	0.13%	28.3%	100.0%
SA3	14,105	97,217	225,851	449	45,062	382,684
Percent	3.7%	25.4%	59.0%	0.12%	11.8%	100.0%
SA4	20,321	54,238	287,682	879	59,471	422,591
Percent	4.8%	12.8%	68.1%	0.21%	14.1%	100.0%
SA5	7,382	17,402	29,410	99	52,329	106,622
Percent	6.9%	16.3%	27.6%	0.09%	49.1%	100.0%
SA6	107,513	9,248	340,095	827	8,135	465,818
Percent	23.1%	2.0%	73.0%	0.18%	1.7%	100.0%
SA7	7,371	13,275	292,487	557	21,743	335,433
Percent	2.2%	4.0%	87.2%	0.17%	6.5%	100.0%
SA8	63,721	40,894	246,641	897	44,293	396,446
Percent	16.1%	10.3%	62.2%	0.23%	11.2%	100.0%
Total	265,439	263,128	1,799,386	4,795	393,969	2,726,717
Percent	9.7%	9.6%	66.0%	0.18%	14.4%	100.0%

Note: Bold values represent highest and lowest percent within each ethnic group across Service Areas.

Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Ethnicity

SA 1 at 24.2% has the highest percentage of African Americans living at or below 138% FPL as compared with the lowest percentage in SA 7 at 2.2%. Of the County's population living at or below 138% FPL, 9.7% self-identify as African American.

SA 3 at 25.4% has the highest percentage of Asian/Pacific Islanders (API) living at or below 138% FPL as compared with the lowest percentage in SA 1 at 1.6%. Of the County's population living at or below 138% FPL, 9.6% self-identify as API.

SA 7 at 87.2% has the highest percentage of Latinos living at or below 138% FPL as compared with the lowest percentage in SA 5 at 27.6%. Of the County's population living at or below 138% FPL, 66.0% self-identify as Latino.

SA 1 at 0.40% has the highest percentage of Native Americans living at or below 138% FPL as compared with the lowest percentage in SAs 5 at 0.09%. Of the County's population living at or below 138% FPL, 0.18% self-identify as Native American.

SA 5 at 49.1% has highest percentage of Whites living at or below 138% FPL as compared with the lowest percentage in SA 6 at 1.7%. Of the County's population living at or below 138% FPL, 14.4% self-identify as White.

**TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138%
FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA
CY 2013**

Service Area (SA)	Age Group						Total
	0-18	19-20	21-25	26-59	60-64	65+	
SA1	50,852	4,647	10,492	44,053	3,766	5,540	119,350
Percent	42.6%	3.9%	8.8%	36.9%	3.2%	4.6%	100.0%
SA2	173,822	14,877	40,726	225,611	19,510	36,669	511,215
Percent	34.0%	2.9%	8.0%	44.1%	3.8%	7.2%	100.0%
SA3	131,013	12,214	31,907	164,630	16,720	31,560	388,044
Percent	33.8%	3.1%	8.2%	42.4%	4.3%	8.1%	100.0%
SA4	131,122	10,713	32,410	203,934	16,256	33,832	428,267
Percent	30.6%	2.5%	7.6%	47.6%	3.8%	7.9%	100.0%
SA5	17,904	2,317	16,654	60,353	4,374	8,930	110,532
Percent	16.2%	2.1%	15.1%	54.6%	4.0%	8.1%	100.0%
SA6	197,447	15,196	42,322	180,843	13,882	20,806	470,496
Percent	42.0%	3.2%	9.0%	38.4%	3.0%	4.4%	100.0%
SA7	140,563	10,273	24,786	128,721	11,235	21,715	337,293
Percent	41.7%	3.0%	7.3%	38.2%	3.3%	6.4%	100.0%
SA8	150,571	12,591	33,859	172,294	14,316	21,034	404,665
Percent	37.2%	3.1%	8.4%	42.6%	3.5%	5.2%	100.0%
Total	993,294	82,828	233,156	1,180,442	100,059	180,086	2,769,862
Percent	35.9%	3.0%	8.4%	42.6%	3.6%	6.5%	100.0%

Note: Age groups relevant to the Affordable Care Act are used in the 138% table by contrast with other age group tables. Bold values represent highest and lowest percent within each age group across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Age Group

SA 1 at 42.6% has the highest percentage of 0-18 year olds estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 5 at 16.2% living at or below 138% FPL.

SA 1 at 3.9% has the highest percentage of 19-20 year olds estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 5 at 2.1% living at or below 138% FPL.

SA 5 at 15.1% has the highest percentage of 21-25 year olds estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 7 at 7.3% living at or below 138% FPL.

SA 5 at 54.6% has the highest percentage of 26-59 year olds estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 1 at 36.9% living at or below 138% FPL.

SA 3 at 4.3% has the highest percentage of 60-64 year olds estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 6 at 3.0% living at or below 138% FPL.

SAs 3 and 5 at 8.1% have the highest percentage of 65 year old and over estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 6 at 4.4% living at or below 138% FPL.

**TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW
138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA
CY 2013**

Service Area (SA)	Male	Female	Total
SA1	54,961	64,389	119,350
Percent	46.1%	53.9%	100.0%
SA2	240,159	271,056	511,215
Percent	47.0%	53.0%	100.0%
SA3	180,141	207,903	388,044
Percent	46.4%	53.6%	100.0%
SA4	205,966	222,301	428,267
Percent	48.1%	51.9%	100.0%
SA5	51,300	59,232	110,532
Percent	46.4%	53.6%	100.0%
SA6	216,240	254,256	470,496
Percent	46.0%	54.0%	100.0%
SA7	155,994	181,299	337,293
Percent	46.2%	53.8%	100.0%
SA8	186,480	218,185	404,665
Percent	46.1%	53.9%	100.0%
Total	1,291,241	1,478,621	2,769,862
Percent	46.6%	53.4%	100.0%

Note: Bold values represent highest and lowest percent within each gender across Service Areas. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Gender

SA 4 at 48.1% has the highest percentage of Males estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 6 at 46.0%.

SA 6 at 51.9% has the highest percentage of Females estimated to be living at or below 138% FPL as compared with the lowest percentage in SA 4 at 54.0%.

**TABLE 7: ESTIMATED PREVALENCE OF SED & SMI
AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY
LEVEL (FPL) BY ETHNICITY AND SERVICE AREA
CY 2013**

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Total
SA1	4,451	137	7,377	111	2,354	14,430
Percent Within Ethnic Group	10.6%	0.7%	3.6%	9.6%	5.4%	4.6%
Percent Within SA	30.8%	1.0%	51.1%	0.8%	16.3%	100.0%
SA2	2,663	2,115	35,626	150	15,569	56,124
Percent Within Ethnic Group	6.4%	11.0%	17.4%	13.0%	35.9%	18.1%
Percent Within SA	4.7%	3.8%	63.5%	0.3%	27.7%	100.0%
SA3	2,229	7,097	25,747	108	4,957	40,137
Percent Within Ethnic Group	5.3%	36.9%	12.6%	9.4%	11.4%	12.9%
Percent Within SA	5.6%	17.7%	64.1%	0.3%	12.4%	100.0%
SA4	3,211	3,959	32,796	211	6,542	46,719
Percent Within Ethnic Group	7.7%	20.6%	16.0%	18.3%	15.1%	15.0%
Percent Within SA	6.9%	8.5%	70.2%	0.5%	14.0%	100.0%
SA5	1,166	1,270	3,353	24	5,756	11,570
Percent Within Ethnic Group	2.8%	6.6%	1.6%	2.1%	13.3%	3.7%
Percent Within SA	10.1%	11.0%	29.0%	0.2%	49.8%	100.0%
SA6	16,987	675	38,771	198	895	57,526
Percent Within Ethnic Group	40.5%	3.5%	18.9%	17.2%	2.1%	18.5%
Percent Within SA	29.5%	1.2%	67.4%	0.3%	1.6%	100.0%
SA7	1,165	969	33,344	134	2,392	38,004
Percent Within Ethnic Group	2.8%	5.0%	16.3%	11.6%	5.5%	12.2%
Percent Within SA	3.1%	2.5%	87.7%	0.4%	6.3%	100.0%
SA8	10,068	2,985	28,117	215	4,872	46,257
Percent Within Ethnic Group	24.0%	15.5%	13.7%	18.7%	11.2%	14.9%
Percent Within SA	21.8%	6.5%	60.8%	0.5%	10.5%	100.0%
Total	41,939	19,208	205,131	1,151	43,337	310,767
Percent Within Ethnic Group	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Percent Across Ethnicity	13.5%	6.2%	66.0%	0.4%	13.9%	100.0%

Note: Bold values represent highest percent within each ethnic group across Service Areas. Values in italics represent highest percent across ethnic groups within a Service Area. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Ethnicity

Table 7 compares the prevalence of SED and SMI for population living at or below 138% FPL for each ethnic group: 1) within each ethnicity and, 2) within each SA.

Within the African American ethnic group, the highest rate of prevalence of SED and SMI is in SA 6 at 40.5%. However within SA the highest rate of prevalence among African Americans is in SA 1 at 30.8%.

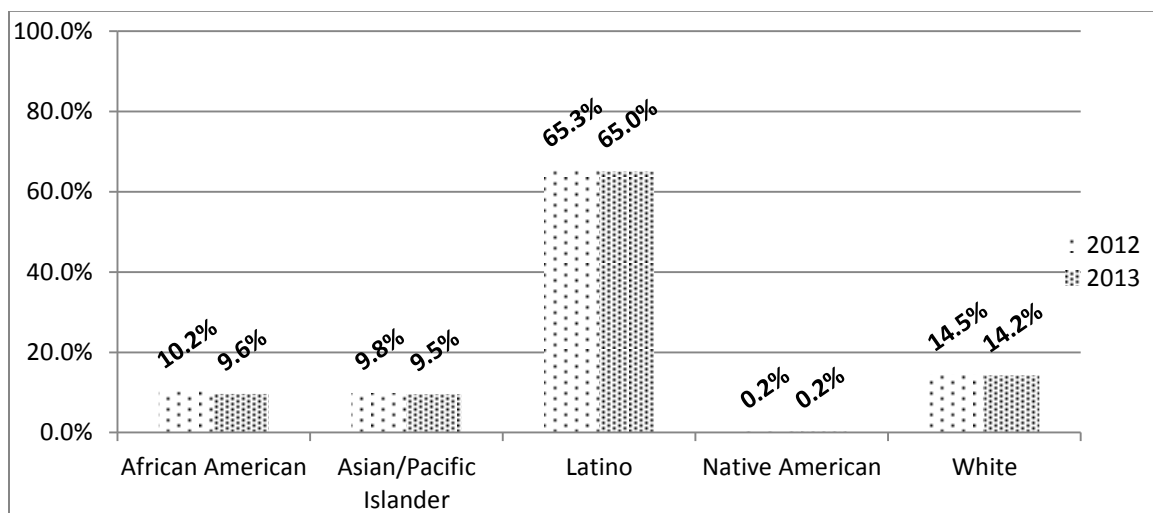
Within the Asian/Pacific Islander (API) ethnic group, the highest rate of prevalence of SED and SMI is in SA 3 at 36.9%. Within SA the highest rate of prevalence among API is also in SA 3 at 17.7%.

Within the Latino ethnic group, the highest rate of prevalence of SED and SMI is in SA 6 at 18.9%. However within SA the highest rate of prevalence among Latinos is in SA 7 at 87.7%.

Within the Native American ethnic group, the highest rate of prevalence of SED and SMI is in SA 8 at 18.7%. However within SA the highest rate of prevalence among Native Americans is in SA 1 at 0.8%.

Within the White ethnic group, the highest rate of prevalence of SED and SMI is in SA 2 at 35.9%. However within SA the highest rate of prevalence among Whites is in SA 5 at 49.8%.

**FIGURE 5: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY
CY 2012 - 2013**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

The percent of African Americans living at or below 138% FPL has decreased by 0.6% from 10.2% in 2012 to 9.6% in 2013.

The percent of Asian/Pacific Islanders (API) living at or below 138% FPL has decreased by 0.3% from 9.8% in 2012 to 9.5% in 2013.

The percent of Latinos living at or below 138% FPL has decreased by 0.3% from 65.3% in 2012 to 65.0% in 2013.

The percent of Native Americans living at or below 138% FPL has remained unchanged at 0.2% from 2012 to 2013.

The percent of Whites living at or below 138% FPL has decreased by 0.3% from 14.5% in 2012 to 14.2% in 2013.

**TABLE 8: ESTIMATED PREVALENCE OF SED & SMI
AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY
LEVEL (FPL) BY AGE GROUP AND SERVICE AREA
CY 2013**

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	6,814	339	1,112	5,639	441	432	14,777
Percent Within Age Group	5.1%	5.6%	4.5%	3.7%	3.8%	3.1%	4.3%
Percent Within SA	46.1%	2.3%	7.5%	38.2%	3.0%	2.9%	100.0%
SA2	23,292	1,086	4,317	28,878	2,283	2,860	62,716
Percent Within Age Group	17.5%	18.0%	17.5%	19.1%	19.5%	20.4%	18.4%
Percent Within SA	37.1%	1.7%	6.9%	46.0%	3.6%	4.6%	100.0%
SA3	17,556	892	3,382	21,073	1,956	2,462	47,320
Percent Within Age Group	13.2%	14.8%	13.7%	13.9%	16.7%	17.5%	13.9%
Percent Within SA	37.1%	1.9%	7.1%	44.5%	4.1%	5.2%	100.0%
SA4	17,570	782	3,435	26,104	1,902	2,639	52,432
Percent Within Age Group	13.2%	12.9%	13.9%	17.3%	16.2%	18.8%	15.4%
Percent Within SA	33.5%	1.5%	6.6%	49.8%	3.6%	5.0%	100.0%
SA5	2,399	169	1,765	7,725	512	697	13,267
Percent Within Age Group	1.8%	2.8%	7.1%	5.1%	4.4%	5.0%	3.9%
Percent Within SA	18.1%	1.3%	13.3%	58.2%	3.9%	5.3%	100.0%
SA6	26,458	1,109	4,486	23,148	1,624	1,623	58,448
Percent Within Age Group	19.9%	18.3%	18.2%	15.3%	13.9%	11.6%	17.2%
Percent Within SA	45.3%	1.9%	7.7%	39.6%	2.8%	2.8%	100.0%
SA7	18,835	750	2,627	16,476	1,314	1,694	41,697
Percent Within Age Group	14.2%	12.4%	10.6%	10.9%	11.2%	12.1%	12.2%
Percent Within SA	45.2%	1.8%	6.3%	39.5%	3.2%	4.1%	100.0%
SA8	20,177	919	3,589	22,054	1,675	1,641	50,054
Percent Within Age Group	15.2%	15.2%	14.5%	14.6%	14.3%	11.7%	14.7%
Percent Within SA	40.3%	1.8%	7.2%	44.1%	3.3%	3.3%	100.0%
Total	133,101	6,046	24,715	151,096	11,707	14,047	340,712
Percent Within Age Group	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Percent Across Age Group	39.1%	1.8%	7.3%	44.3%	3.4%	4.1%	100.0%

Note: Bold values represent highest percent within each age group across Service Areas. Values in italics represent highest percent across age groups within a Service Area. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

Differences by Age Group

Table 8 compares the prevalence of SED and SMI for population living at or below 138% FPL for each age group: 1) within each age group and, 2) within each SA.

Within 0-18 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 19.9%. However within SA the highest rate of prevalence among 0-18 year olds is in SA 1 at 46.1%.

Within 19-20 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 18.3%. However within SA the highest rate of prevalence among 19-20 year olds is in SA 1 at 2.3%.

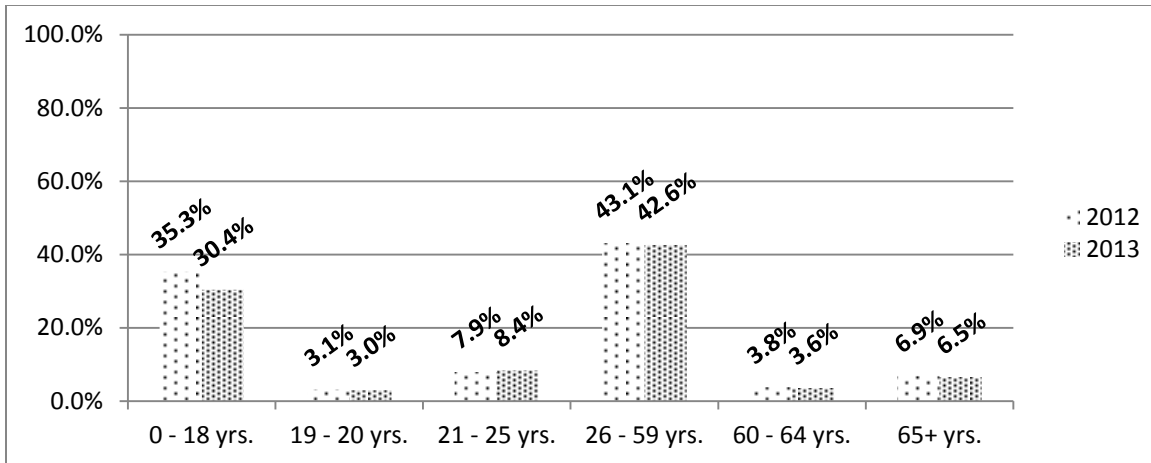
Within 21-25 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 18.2%. However within SA the highest rate of prevalence among 21-25 year olds is in SA 5 at 13.3%.

Within 26-59 year olds, the highest rate of prevalence of SED and SMI is in SA 2 at 19.1%. However within SA the highest rate of prevalence among 26-59 year olds is in SA 5 at 58.2%.

Within 60-64 year olds, the highest rate of prevalence of SED and SMI is in SA 2 at 19.5%. However within SA the highest rate of prevalence among 60-64 year olds is in SA 3 at 4.1%.

Within 65+ year olds, the highest rate of prevalence of SED and SMI is in SA 2 at 20.4%. However within SA the highest rate of prevalence among 65+ year olds is in SA 5 at 5.3%.

**FIGURE 6: ESTIMATED POVERTY PERCENT CHANGE AMONG
POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL
(FPL) BY AGE GROUP
CY 2012 – 2013**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

The percentage of 0-18 year olds living at or below 138% FPL decreased by 4.9% from 35.3% in 2012 to 30.4% in 2013.

The percentage of 19-20 year olds living at or below 138% FPL decreased by 0.1% from 3.1% in 2012 to 3.0% in 2013.

The percentage of 21-25 year olds living at or below 138% FPL increased by 0.5% from 7.9% in 2012 to 8.4% in 2013.

The percentage of 26-59 year olds living at or below 138% FPL decreased by 0.5% from 43.1% in 2012 to 42.6% in 2013.

The percentage of 60-64 year olds living at or below 138% FPL decreased by 0.2% from 3.8% in 2012 to 3.6% in 2013.

The percentage of 65+ year olds living at or below 138% FPL decreased by 0.4% from 6.9% in 2012 to 6.5% in 2013.

**TABLE 9: ESTIMATED PREVALENCE OF SED & SMI
AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY
LEVEL (FPL) BY GENDER AND SERVICE AREA
CY 2013**

Service Area (SA)	Male	Female	Total
SA1	5,881	7,662	13,543
Percent Within Gender	4.3%	4.4%	4.3%
Percent Within SA	43.4%	56.6%	100.0%
SA2	25,697	32,256	57,953
Percent Within Gender	18.6%	18.3%	18.4%
Percent Within SA	44.3%	55.7%	100.0%
SA3	19,275	24,740	44,016
Percent Within Gender	14.0%	14.1%	14.0%
Percent Within SA	43.8%	56.2%	100.0%
SA4	22,038	26,454	48,492
Percent Within Gender	16.0%	15.0%	15.4%
Percent Within SA	<i>45.4%</i>	54.6%	100.0%
SA5	5,489	7,049	12,538
Percent Within Gender	4.0%	4.0%	4.0%
Percent Within SA	43.8%	56.2%	100.0%
SA6	23,138	30,256	53,394
Percent Within Gender	16.7%	17.2%	17.0%
Percent Within SA	43.3%	<i>56.7%</i>	100.0%
SA7	16,691	21,575	38,266
Percent Within Gender	12.1%	12.3%	12.2%
Percent Within SA	43.6%	56.4%	100.0%
SA8	19,953	25,964	45,917
Percent Within Gender	14.4%	14.8%	14.6%
Percent Within SA	43.5%	56.5%	100.0%
Total	138,163	175,956	314,119
Total Percent Within Gender	100.0%	100.0%	100.0%
Total Percent Across Gender	44.0%	56.0%	100.0%

Note: Bold values represent highest percent within each gender across Service Areas. Values in italics represent highest percent across each gender within a Service Area. Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

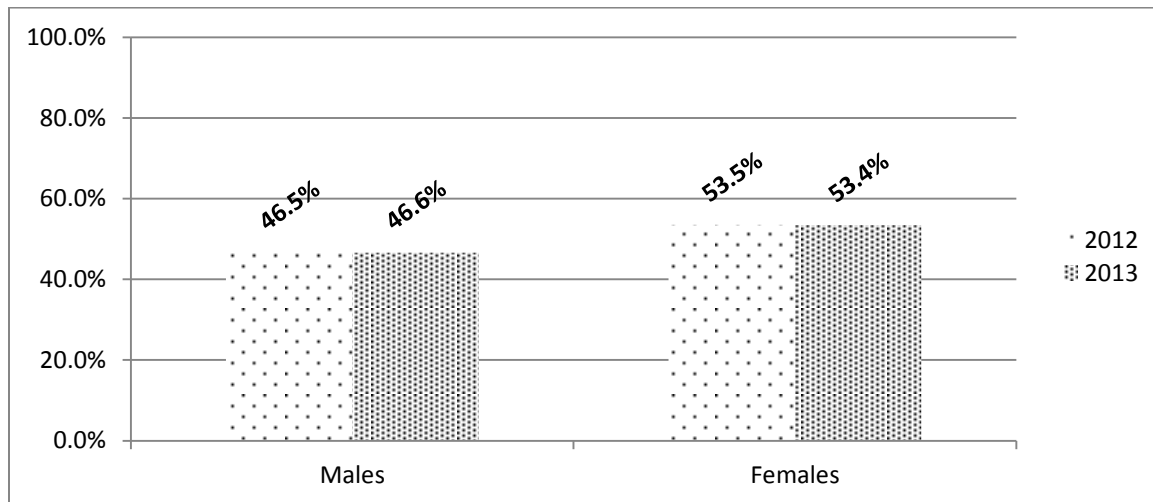
Differences by Gender

Table 9 compares the prevalence of SED and SMI for population living at or below 138% FPL for males and females: 1) within gender and, 2) within each SA.

Within males the highest rate of prevalence of SED and SMI is in SA 2 at 18.6%. However within SA the highest rate of prevalence among males is in SA 4 at 45.4%.

Within females the highest rate of prevalence of SED and SMI is in SA 2 at 18.3%. However within SA the highest rate of prevalence among females is in SA 6 at 56.7%.

**FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER
CY 2012 - 2013**



Data Source: American Community Survey, US Census Bureau and Hedderson Demographic Services, 2013.

The percentage of males living at or below 138% FPL increased by 0.1% from 46.5% in 2012 to 46.6% in 2013. The percentage of females living at or below 138% FPL decreased by 0.1% from 53.5% in 2012 to 53.4% in 2013.

Population Enrolled in Medi-Cal

**TABLE 10: POPULATION ENROLLED IN MEDI-CAL
BY ETHNICITY AND SERVICE AREA
MARCH 2014**

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Total
SA1	26,146	2,013	50,099	236	18,439	96,933
Percent	27.0%	2.1%	51.7%	0.24%	19.0%	100.0%
SA2	13,602	22,304	194,744	409	113,613	344,672
Percent	3.9%	6.5%	56.5%	0.12%	33.0%	100.0%
SA3	12,543	35,910	178,367	378	30,203	257,401
Percent	4.9%	14.0%	69.3%	0.15%	11.7%	100.0%
SA4	13,915	25,832	156,416	314	27,602	224,079
Percent	6.2%	11.5%	69.8%	0.14%	12.3%	100.0%
SA5	5,439	2,566	14,510	113	16,979	39,607
Percent	13.7%	6.5%	36.6%	0.29%	42.9%	100.0%
SA6	91,673	3,175	229,770	228	7,275	332,121
Percent	27.6%	1.0%	69.2%	0.07%	2.2%	100.0%
SA7	8,210	11,370	223,261	349	18,283	261,473
Percent	3.1%	4.3%	85.4%	0.13%	7.0%	100.0%
SA8	54,557	27,693	143,967	430	25,501	252,148
Percent	21.6%	11.0%	57.1%	0.17%	10.1%	100.0%
Total	226,085	130,863	1,191,134	2,457	257,895	1,808,434
Percent	12.5%	7.2%	65.9%	0.14%	14.3%	100.0%

Note: Bold values represent highest and lowest percent within each ethnic group across Service Areas.

Data Source: State MEDS File, March 2014.

Differences by Ethnicity

SA 6 at 27.6% has the highest percentage of African Americans enrolled in Medi-Cal as compared with the lowest in SA 7 at 3.1%.

SA 3 at 14.0% has the highest percentage of Asian/Pacific Islanders (API) enrolled in Medi-Cal as compared with the lowest in SA 6 at 1.0%.

SA 7 at 85.4% has the highest percentage of Latinos enrolled in Medi-Cal as compared with the lowest in SA 5 at 36.6%.

SA 5 at 0.29% has the highest percentage of Native Americans enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.07%.

SA 5 at 42.9% has the highest percentage of Whites enrolled in Medi-Cal as compared with the lowest in SA 6 at 2.2%.

**TABLE 11: POPULATION ENROLLED IN MEDI-CAL
BY AGE GROUP AND SERVICE AREA
MARCH 2014**

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	54,913	4,406	5,979	27,692	2,654	9,015	104,659
Percent	52.5%	4.2%	5.7%	26.5%	2.5%	8.6%	100.0%
SA2	173,124	13,942	13,286	86,435	13,328	81,586	381,701
Percent	45.4%	3.7%	3.5%	22.6%	3.5%	21.4%	100.0%
SA3	151,786	12,519	12,957	71,726	8,704	71,878	329,570
Percent	46.1%	3.8%	3.9%	21.8%	2.6%	21.8%	100.0%
SA4	117,110	9,279	8,934	52,130	8,346	58,637	254,436
Percent	46.0%	3.6%	3.5%	20.5%	3.3%	23.0%	100.0%
SA5	17,195	1,423	1,541	11,839	2,019	13,843	47,860
Percent	35.9%	3.0%	3.2%	24.7%	4.2%	28.9%	100.0%
SA6	204,037	15,454	17,879	78,410	9,277	35,924	360,981
Percent	56.5%	4.3%	5.0%	21.7%	2.6%	10.0%	100.0%
SA7	155,036	11,583	12,735	58,079	6,617	43,848	287,898
Percent	53.9%	4.0%	4.4%	20.2%	2.3%	15.2%	100.0%
SA8	144,806	11,429	12,962	68,394	8,341	41,530	287,462
Percent	50.4%	4.0%	4.5%	23.8%	2.9%	14.4%	100.0%
Total	1,018,007	80,035	86,273	454,705	59,286	356,261	2,054,567
Percent	49.5%	3.9%	4.2%	22.1%	2.9%	17.3%	100.0%

Note: Bold values represent highest and lowest percent within each age group across Service Areas.
Data Source: State MEDS File, March 2014.

Differences by Age Group

SA 6 at 56.5% had the highest percentage of 0-18 year olds enrolled in Medi-Cal as compared to the lowest in SA 5 at 35.9%.

SA 1 at 4.2% had the highest percentage of 19-20 year olds enrolled in Medi-Cal as compared to the lowest in SA 5 at 3.0%.

SA 1 at 5.7% had the highest percentage of 21-25 year olds enrolled in Medi-Cal as compared to the lowest in SA 5 at 3.2%.

SA 1 at 26.5% had the highest percentage of 26-59 year olds enrolled in Medi-Cal as compared to the lowest in SA 7 at 20.2%.

SA 5 at 4.2% had the highest percentage of 60-64 year olds enrolled in Medi-Cal living as compared to the lowest in SA 7 at 2.3%.

SA 5 at 28.9% had the highest percentage of 65 year olds enrolled in Medi-Cal as compared to the lowest in SA 1 at 8.6%.

**TABLE 12: POPULATION ENROLLED IN MEDI-CAL
BY GENDER AND SERVICE AREA
MARCH 2014**

Service Area (SA)	Male	Female	Total
SA1	45,918	58,741	104,659
Percent	43.9%	56.1%	100.0%
SA2	169,325	212,376	381,701
Percent	44.4%	55.6%	100.0%
SA3	145,516	184,054	329,570
Percent	44.2%	55.8%	100.0%
SA4	115,234	139,202	254,436
Percent	45.3%	54.7%	100.0%
SA5	21,401	26,459	47,860
Percent	44.7%	55.3%	100.0%
SA6	160,368	200,613	360,981
Percent	44.4%	55.6%	100.0%
SA7	127,199	160,699	287,898
Percent	44.2%	55.8%	100.0%
SA8	126,368	161,094	287,462
Percent	44.0%	56.0%	100.0%
Total	911,329	1,143,238	2,054,567
Percent	44.4%	55.6%	100.0%

Note: Bold values represent highest and lowest percent within each gender across Service Areas. Data Source: State MEDS File, March 2014.

Differences by Gender

SA 4 at 45.3% had the highest percentage of Males enrolled in Medi-Cal as compared with the lowest in SA 1 at 43.9%. SA 1 at 56.1% had the highest percentage of Females enrolled in Medi-Cal compared with the lowest in SA 4 at 54.7%.

**TABLE 13: ESTIMATED PREVALENCE OF SED & SMI AMONG MEDICAL
ENROLLED POPULATION BY ETHNICITY AND SERVICE AREA
MARCH 2014**

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Total
SA1	3,843	131	5,711	59	2,637	12,381
Percent Within Ethnic Group	11.6%	1.5%	4.2%	9.6%	7.1%	5.8%
Percent Within SA	31.0%	1.1%	46.1%	0.5%	21.3%	100.0%
SA2	1,999	1,450	22,201	102	16,247	41,999
Percent Within Ethnic Group	6.0%	17.0%	16.3%	16.6%	44.1%	19.5%
Percent Within SA	4.8%	3.5%	52.9%	0.2%	38.7%	100.0%
SA3	1,844	2,334	20,334	94	4,319	28,925
Percent Within Ethnic Group	5.5%	27.4%	15.0%	15.4%	11.7%	13.5%
Percent Within SA	6.4%	8.1%	70.3%	0.3%	14.9%	100.0%
SA4	2,046	1,679	17,831	78	3,947	25,581
Percent Within Ethnic Group	6.2%	19.7%	13.1%	12.8%	10.7%	11.9%
Percent Within SA	8.0%	6.6%	69.7%	0.3%	15.4%	100.0%
SA5	800	167	1,654	28	2,428	5,077
Percent Within Ethnic Group	2.4%	2.0%	1.2%	4.6%	6.6%	2.4%
Percent Within SA	15.7%	3.3%	32.6%	0.6%	47.8%	100.0%
SA6	13,476	206	26,194	57	1,040	40,973
Percent Within Ethnic Group	40.5%	2.4%	19.3%	9.3%	2.8%	19.1%
Percent Within SA	32.9%	0.5%	63.9%	0.1%	2.5%	100.0%
SA7	1,207	739	25,452	87	2,614	30,099
Percent Within Ethnic Group	3.6%	8.7%	18.7%	14.2%	7.1%	14.0%
Percent Within SA	4.0%	2.5%	84.6%	0.3%	8.7%	100.0%
SA8	8,020	1,800	16,412	107	3,647	29,986
Percent Within Ethnic Group	24.1%	21.2%	12.1%	17.5%	9.9%	13.9%
Percent Within SA	26.7%	6.0%	54.7%	0.4%	12.2%	100.0%
Total	33,234	8,506	135,789	612	36,879	215,021
Percent Within Ethnic Group	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Percent Across Ethnicity	15.5%	4.0%	63.2%	0.3%	17.2%	100.0%

Note: Bold values represent highest percent within each ethnic group across Service Areas. Values in italics represent highest percent across ethnic groups within a Service Area. Estimated prevalence rates of mental illness by ethnicity for the County of Los Angeles are provided by the California Health Interview Survey (CHIS) for population living at or below 100% FPL.

Differences by Ethnicity

Table 13 compares the prevalence of SED and SMI among Medi-Cal enrolled population for each ethnic group by 1) within each ethnicity and, 2) within each SA.

Within African Americans, the highest rate of prevalence of SED and SMI is in SA 6 at 40.5%. Similarly within SA the highest rate of prevalence among African Americans is also in SA 6 at 32.9%.

Within Asian/Pacific Islanders (API), the highest rate of prevalence of SED and SMI is in SA 3 at 27.4%. Similarly within SA the highest rate of prevalence among API is also in SA 3 at 8.1%.

Within Latinos, the highest rate of prevalence of SED and SMI is in SA 6 at 19.3%. However within SA the highest rate of prevalence among Latino is in SA 7 at 84.6%.

Within Native Americans, the highest rate of prevalence of SED and SMI is in SA 8 at 17.5%. However within SA the highest rate of prevalence among Native American is in SA 5 at 0.6%.

Within White ethnic groups, the highest rate of prevalence of SED and SMI is in SA 2 at 44.1%. However within SA the highest rate of prevalence among Whites is in SA 5 at 47.8%.

**TABLE 14: ESTIMATED PREVALENCE OF SED & SMI AMONG MEDI-CAL
ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA
MARCH 2014**

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	8,017	375	717	3,572	332	658	13,671
Percent Within Age Group	5.4%	5.5%	6.9%	6.1%	1.1%	2.5%	4.9%
Percent Within SA	58.6%	2.7%	5.2%	26.1%	2.4%	4.8%	100.0%
SA2	25,276	1,185	1,594	11,150	1,666	5,956	46,827
Percent Within Age Group	17.0%	17.4%	15.4%	19.0%	5.6%	22.9%	16.7%
Percent Within SA	54.0%	2.5%	3.4%	23.8%	3.6%	12.7%	100.0%
SA3	22,161	1,064	1,555	9,253	1,088	5,247	40,367
Percent Within Age Group	14.9%	15.6%	15.0%	15.8%	3.6%	20.2%	14.4%
Percent Within SA	54.9%	2.6%	3.9%	22.9%	2.7%	13.0%	100.0%
SA4	17,098	789	1,072	6,725	1,043	4,281	31,007
Percent Within Age Group	11.5%	11.6%	10.4%	11.5%	3.5%	16.5%	11.1%
Percent Within SA	55.1%	2.5%	3.5%	21.7%	3.4%	13.8%	100.0%
SA5	2,510	121	185	1,527	252	1,011	5,606
Percent Within Age Group	1.7%	1.8%	1.8%	2.6%	0.8%	3.9%	2.0%
Percent Within SA	44.8%	2.2%	3.3%	27.2%	4.5%	18.0%	100.0%
SA6	29,789	1,314	2,145	10,115	9,801	2,622	55,787
Percent Within Age Group	20.0%	19.3%	20.7%	17.2%	32.7%	10.1%	19.9%
Percent Within SA	53.4%	2.4%	3.8%	18.1%	17.6%	4.7%	100.0%
SA7	22,635	985	1,528	7,492	7,260	3,201	43,101
Percent Within Age Group	15.2%	14.5%	14.8%	12.8%	24.2%	12.3%	15.4%
Percent Within SA	52.5%	2.3%	3.5%	17.4%	16.8%	7.4%	100.0%
SA8	21,142	971	1,555	8,823	8,549	3,032	44,072
Percent Within Age Group	14.2%	14.3%	15.0%	15.0%	28.5%	11.7%	15.7%
Percent Within SA	48.0%	2.2%	3.5%	20.0%	19.4%	6.9%	100.0%
Total	148,629	6,803	10,353	58,657	29,992	26,007	280,441
Percent Within Age Group	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Percent Across Age Group	53.0%	2.4%	3.7%	20.9%	10.7%	9.3%	100.0%

Note: Bold values represent highest percent within each age group across Service Areas. Values in italics represent highest percent across age groups within a Service Area. Estimated prevalence rates of mental illness by age group for the County of Los Angeles are provided by the California Health Interview Survey (CHIS) for population living at or below 100% FPL.

Differences by Age Group

Table 14 compares the prevalence of SED and SMI among Medi-Cal enrolled population for each age group: 1) within each age group and, 2) within each SA.

Within 0-18 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 20.0%. However within SA the highest rate of prevalence among 0-18 year olds is in SA 1 at 58.6%.

Within 19-20 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 19.3%. However within SA the highest rate of prevalence among 19-20 year olds is in SA 1 at 2.7%.

Within 21-25 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 20.7%. However within SA the highest rate of prevalence among 21-25 year olds is in SA 1 at 5.2%.

Within 26-59 year olds, the highest rate of prevalence of SED and SMI is in SA 2 at 19.0%. However within SA the highest rate of prevalence among 26-59 year olds is in SA 5 at 27.2%.

Within 60-64 year olds, the highest rate of prevalence of SED and SMI is in SA 6 at 32.7%. Similarly within SA the highest rate of prevalence among 60-64 year olds is also in SA 6 at 17.6%.

Within 65+ year olds, the highest rate of prevalence of SED and SMI is in SA 2 at 22.9%. However within SA the highest rate of prevalence among 65+ year olds is in SA 5 at 18.0%.

**TABLE 15: ESTIMATED PREVALENCE OF SED & SMI AMONG MEDICAL
ENROLLED POPULATION BY GENDER AND SERVICE AREA
MARCH 2014**

Service Area (SA)	Male	Female	Total
SA1	5,143	7,049	12,192
Percent Within Gender	5.0%	5.1%	5.1%
Percent Within SA	42.2%	57.8%	100.0%
SA2	18,964	25,485	44,450
Percent Within Gender	18.6%	18.6%	18.6%
Percent Within SA	42.7%	57.3%	100.0%
SA3	16,298	22,086	38,384
Percent Within Gender	16.0%	16.1%	16.0%
Percent Within SA	42.5%	57.5%	100.0%
SA4	12,906	16,704	29,610
Percent Within Gender	12.6%	12.2%	12.4%
Percent Within SA	43.6%	56.4%	100.0%
SA5	2,397	3,175	5,572
Percent Within Gender	2.3%	2.3%	2.3%
Percent Within SA	43.0%	57.0%	100.0%
SA6	17,961	24,074	42,035
Percent Within Gender	17.6%	17.5%	17.6%
Percent Within SA	42.7%	57.3%	100.0%
SA7	14,246	19,284	33,530
Percent Within Gender	14.0%	14.1%	14.0%
Percent Within SA	42.5%	57.5%	100.0%
SA8	14,153	19,331	33,484
Percent Within Gender	13.9%	14.1%	14.0%
Percent Within SA	42.3%	57.7%	100.0%
Total	102,069	137,189	239,257
Total Percent Within Gender	100.0%	100.0%	100.0%
Total Percent Across Gender	42.7%	57.3%	100.0%

Note: Bold values represent highest percent within each gender across Service Areas. Values in italics represent highest percent for males and females within a Service Area. Estimated prevalence rates of mental illness by gender for the County of Los Angeles are provided by the California Health Interview Survey (CHIS) for population living at or below 100% FPL.

Differences by Gender

Table 15 compares the prevalence of SED and SMI among Medi-Cal enrolled population for males and females by 1) within gender and, 2) within each SA.

Within males, the highest rate of prevalence of SED and SMI is in SA 2 at 18.6%. However within SA the highest rate of prevalence among males is in SA 4 at 43.6%.

Within females, the highest rate of prevalence of SED and SMI is in SA 2 at 18.6%. However, within SA, the highest rate of prevalence among females is in SA 1 at 57.8%.

**TABLE 16: THRESHOLD LANGUAGES SPOKEN BY POPULATION ENROLLED
IN MEDI-CAL BY SERVICE AREA
MARCH 2014**

Service Area (SA)	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Other	Total
SA1	101	18	30	78,629	31	80	22	18	8	23,687	151	86	152	103,013
Percent	0.1%	0.0%	0.0%	76.3%	0.0%	0.1%	0.0%	0.0%	0.0%	23.0%	0.1%	0.1%	0.1%	100.0%
SA2	48,359	135	205	171,954	6,959	2,762	324	144	4,100	129,596	3,006	2,170	1,949	371,663
Percent	13.0%	0.0%	0.1%	46.3%	1.9%	0.7%	0.1%	0.0%	1.1%	34.9%	0.8%	0.6%	0.5%	100.0%
SA3	1,955	811	19,466	165,508	253	1,559	17,324	2,818	94	92,065	1,812	14,469	1,579	319,713
Percent	0.6%	0.3%	6.1%	51.8%	0.1%	0.5%	5.4%	0.9%	0.0%	28.8%	0.6%	4.5%	0.5%	100.0%
SA4	6,342	497	5,916	97,741	478	11,643	871	485	4,543	113,090	3,001	1,195	1,283	247,085
Percent	2.6%	0.2%	2.4%	39.6%	0.2%	4.7%	0.4%	0.2%	1.8%	45.8%	1.2%	0.5%	0.5%	100.0%
SA5	46	9	54	29,797	3,518	308	166	55	1,354	9,589	78	74	489	45,537
Percent	0.1%	0.0%	0.1%	65.4%	7.7%	0.7%	0.4%	0.1%	3.0%	21.1%	0.2%	0.2%	1.1%	100.0%
SA6	20	96	79	188,097	17	1,082	35	11	25	165,258	92	71	724	355,607
Percent	0.0%	0.0%	0.0%	52.9%	0.0%	0.3%	0.0%	0.0%	0.0%	46.5%	0.0%	0.0%	0.2%	100.0%
SA7	591	776	637	144,625	44	1,770	927	232	61	128,944	906	649	847	281,009
Percent	0.2%	0.3%	0.2%	51.5%	0.0%	0.6%	0.3%	0.1%	0.0%	45.9%	0.3%	0.2%	0.3%	100.0%
SA8	98	5,153	218	175,759	338	2,035	415	174	161	90,667	1,824	2,038	1,259	280,139
Percent	0.0%	1.8%	0.1%	62.7%	0.1%	0.7%	0.1%	0.1%	0.1%	32.4%	0.7%	0.7%	0.4%	100.0%
Total	57,512	7,495	26,605	1,052,110	11,638	21,239	20,084	3,937	10,346	752,896	10,870	20,752	8,282	2,003,766
Percent	2.9%	0.4%	1.3%	52.5%	0.6%	1.1%	1.0%	0.2%	0.5%	37.6%	0.5%	1.0%	0.4%	100.0%

Note: SA Threshold Languages are in bold. Arabic is a countywide threshold language and does not meet threshold language criteria at the SA level and thus is not included, N = 4,496 (0.2%). 8,282 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. 44,914 (2.2%) were "Unknown/Missing" for primary language and were missing a Service Area designation.

Data Source: State MEDS File, March 2014.

Table 16 shows that among the thirteen (13) LACDMH threshold languages, Spanish is the only Non-English threshold language spoken in all of the Service Areas among population enrolled in Medi-Cal.

The Service Area with the highest percentage of Medi-Cal enrolled population with English as the primary language is SA 1 at 76.3%, and the lowest percentage is SA 4 at 39.6%.

The Service Area with the highest percentage of Medi-Cal enrolled population with Spanish as the primary language is SA 6 at 46.5%, and the lowest percentage is SA 5 at 21.1%.

The following highlights threshold languages spoken by Medi-Cal enrollees by Service Area:

SA 1 has two (2) threshold languages: English (76.3%) and Spanish (23.0%).

SA 2 has six (6) threshold languages: Armenian (13.0%), English (46.3%), Farsi (1.9%), Russian (1.1%), Spanish (34.9%), and Tagalog (0.8%).

SA 3 has five (5) threshold languages: Cantonese (6.1%), English (51.8%), Mandarin (5.4%), Spanish (28.8%), and Vietnamese (4.5%).

SA 4 has seven (7) threshold languages: Armenian (2.6%), Cantonese (2.4%), English (39.6%), Korean (4.7%), Russian (1.8%), Spanish (45.6%), and Tagalog (1.2%).

SA 5 has three (3) threshold languages: English (65.4%), Farsi (7.7%), and Spanish (21.1%).

SA 6 has two (2) threshold languages: English (52.9%) and Spanish (46.5%).

SA 7 has two (2) threshold languages: English (51.5%) and Spanish (45.9%).

SA 8 has three (3) threshold languages: Cambodian (1.8%), English (62.7%), and Spanish (32.4%).

Countywide, the highest percentage of Medi-Cal Enrolled with English as the primary language is 52.5% and the second highest is Spanish at 37.6%. All other threshold languages range between 0.2% (Other Chinese) to 2.9% (Armenian).

Consumers Served In Outpatient Short Doyle/Medi-Cal Facilities

**TABLE 17: CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND SERVICE AREA
FY 2013 – 2014**

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Total
SA1	4,297	120	4,120	77	3,092	11,706
Percent	36.70%	1.00%	35.20%	0.66%	26.40%	100.00%
SA2	3,307	1,118	16,423	131	9,614	30,593
Percent	10.80%	3.70%	53.70%	0.43%	31.40%	100.00%
SA3	3,221	2,187	17,264	121	4,282	27,075
Percent	11.90%	8.10%	63.80%	0.45%	15.80%	100.00%
SA4	10,862	2,790	21,811	374	7,008	42,845
Percent	25.40%	6.50%	50.90%	0.87%	16.40%	100.00%
SA5	2,540	245	3,019	48	3,666	9,518
Percent	26.70%	2.60%	31.70%	0.50%	38.50%	100.00%
SA6	16,570	310	15,473	55	1,090	33,498
Percent	49.50%	0.90%	46.20%	0.16%	3.30%	100.00%
SA7	1,819	574	18,292	384	2,795	23,864
Percent	7.60%	2.40%	76.70%	1.61%	11.70%	100.00%
SA8	11,104	2,286	15,391	138	7,037	35,956
Percent	30.90%	6.40%	42.80%	0.38%	19.60%	100.00%
Total	47,343	9,117	102,640	1,192	35,710	196,002
Percent	24.20%	4.70%	52.40%	0.61%	18.20%	100.00%

Note: Bold values represent highest and lowest percent within each ethnic group across Service Areas. Excludes those whose ethnicity is unknown (N = 11,975). Total reflects unduplicated count of consumers served. Some consumers (N = 19,053) were served in more than One SA, leading to a duplicated count of 215,055. Data Source: LACDMH-IS Database, October 2014.

In FY 2013-14 LACDMH served between 260,000 and 270,000 consumers. A majority were served in Short Doyle/Medi-Cal Outpatient clinics (N = 215,055). Approximately 10,000 were served by Fee For Service Outpatient network providers, another 30,000 were served in jails and juvenile halls, and 17,000 were served in acute psychiatric care facilities.

Differences by Ethnicity

SA 6 at 49.5% has the highest percentage of African American consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 7 at 7.6%.

SA 3 at 8.1% has the highest percentage of Asian/Pacific Islander (API) consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest

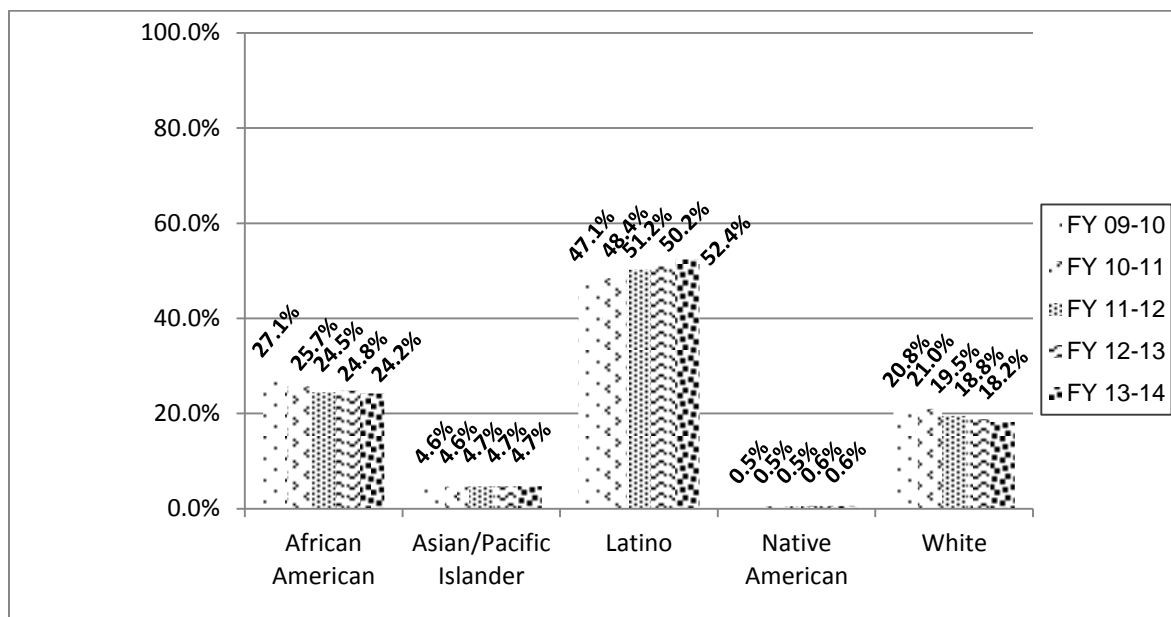
percentage in SA 6 at 0.9%.

SA 7 at 76.7% has the highest percentage of Latino consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 5 at 31.7%.

SA 7 at 1.61% has the highest percentage of Native American consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 6 at 0.16%.

SA 5 at 38.5% has the highest percentage of White consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 6 at 3.3%.

**FIGURE 8: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2009-2010 to FY 2013-2014**



Data Source: LACDMH-IS Database, October 2014.

As a percentage of consumers served, African Americans served in Short Doyle/Medi-Cal facilities decreased by 2.9% from 27.1% to 24.2% between FY 09-10 and FY 13-14. In FY 10-11, the percentage of African Americans served in Short Doyle/Medi-Cal facilities was at 25.7%, in FY 11-12 it was at 24.5%, and in FY 12-13 it was at 24.8%.

As a percentage of consumers served, Asian/Pacific Islanders served in Short Doyle/Medi-Cal facilities increased from 4.6% in FY 09-10 to 4.7% in FY 13-14. In FY 10-11 the percentage of Asian/Pacific Islanders served in Short Doyle/Medi-Cal facilities was at 4.6%, in FY 11-12 it was at 4.7%, and in FY 12-13 it was at 4.7%.

As a percentage of consumers served, Latinos served in Short Doyle/Medi-Cal

facilities increased by 5.3% from 47.1% to 52.4% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of Latinos served in Short Doyle/Medi-Cal facilities was at 48.4%, in FY 11-12 it was at 51.2%, and in FY 12-13 it was at 50.2%.

As a percentage of consumers served, Native Americans served in Short Doyle/Medi-Cal facilities increased from 0.5% in FY 09-10 to 0.6% in FY 2013-2014. In FY 10-11 and FY 11-12 the percentage of Native Americans served in Short Doyle/Medi-Cal facilities was at 0.5%. In FY 12-13, the percentage of Native Americans served in Short Doyle/Medi-Cal facilities was at 0.6%.

As a percentage of consumers served, Whites served in Short Doyle/Medi-Cal facilities decreased by 2.6% from 20.8% to 18.2% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of Whites served in Short Doyle/Medi-Cal facilities was at 21.0%, in FY 11-12 it was at 19.5%, and in FY 12-13 it was at 18.8%.

**TABLE 18: CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE /
MEDI-CAL FACILITIES BY AGE GROUP AND SERVICE AREA
FY 2013 – 2014**

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs	Total
SA1	4,561	1,898	4,800	447	11,706
Percent	39.0%	16.2%	41.0%	3.8%	100.0%
SA2	10,245	5,263	12,877	2,208	30,593
Percent	33.5%	17.2%	42.1%	7.2%	100.0%
SA3	12,562	4,932	8,193	1,388	27,075
Percent	46.4%	18.2%	30.3%	5.1%	100.0%
SA4	12,874	6,179	20,023	3,769	42,845
Percent	30.0%	14.4%	46.7%	8.8%	100.0%
SA5	2,795	1,259	4,454	1,010	9,518
Percent	29.4%	13.2%	46.8%	10.6%	100.0%
SA6	12,992	4,596	14,150	1,760	33,498
Percent	38.8%	13.7%	42.2%	5.3%	100.0%
SA7	10,358	4,039	8,237	1,230	23,864
Percent	43.4%	16.9%	34.5%	5.2%	100.0%
SA8	12,467	5,371	15,831	2,287	35,956
Percent	34.7%	14.9%	44.0%	6.4%	100.0%
Total	70,417	29,806	82,233	13,546	196,002
Percent	35.9%	15.2%	42.0%	6.9%	100.0%

Note: Bold values represent highest and lowest percent within each age group across Service Areas. Total reflects unduplicated count of consumers served. Some consumers (N = 19,053) were served in more than One SA, leading to a duplicated count of 215,055. Data Source: LACDMH-IS Database, October 2014.

Differences by Age Group

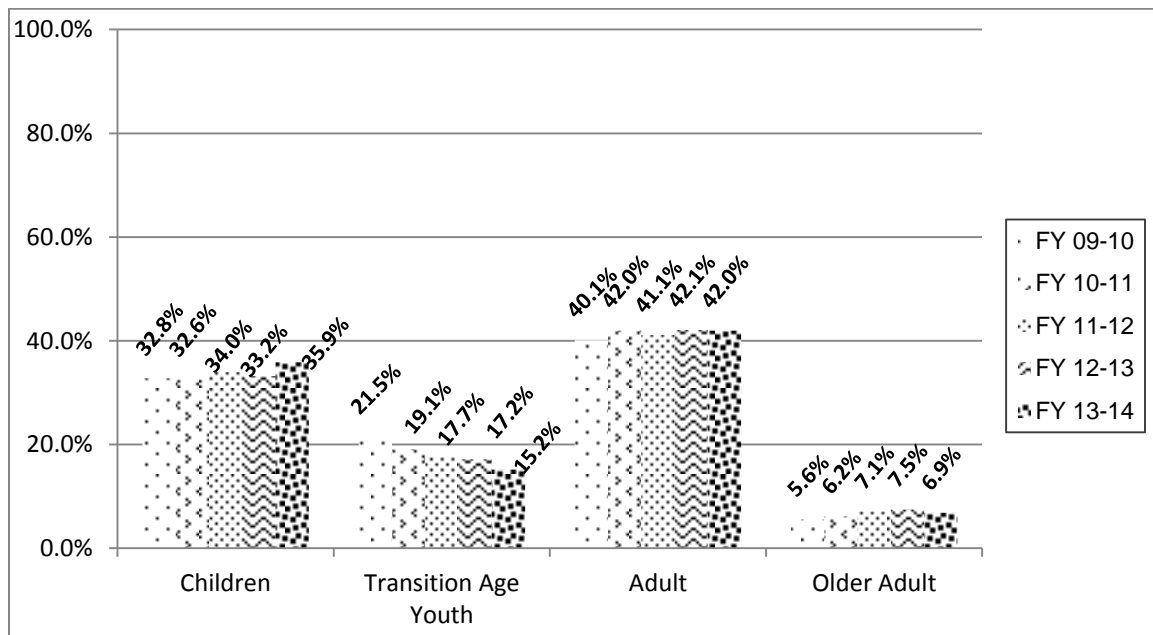
SA 3 at 46.4% has the highest percentage of Children served as compared with the lowest percentage in SA 5 at 29.4%.

SA 3 at 18.2% has the highest percentage of TAY served as compared with the lowest percentage in SA 5 at 13.2%.

SA 5 at 46.8% has the highest percentage of Adults served as compared with the lowest percentage in SA 3 at 30.3%.

SA 5 at 10.6% has the highest percentage of Older Adults served as compared with the lowest percentage in SA 1 at 3.8%.

**FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2009 – 2010 TO FY 2013 – 2014**



Data Source: LACDMH-IS Database, October 2014.

As a percentage of consumers served, children served in Short Doyle/Medi-Cal facilities increased by 3.1% from 32.8% to 35.9% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of Children served in Short Doyle/Medi-Cal facilities was at 32.6%, in FY 11-12 it was at 34.0%, and in FY 12-13 it was at 33.2%.

As a percentage of consumers served, TAY served in Short Doyle/Medi-Cal facilities decreased by 6.3% from 21.5% to 15.2% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of TAY served in Short Doyle/Medi-Cal facilities was at 19.1%, in FY 11-12 it was at 17.7%, and in FY 12-13 it was at 15.2%.

As a percentage of consumers served, Adults served in Short Doyle/Medi-Cal facilities increased by 1.9% from 40.1% to 42.0% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of Adults served in Short Doyle/Medi-Cal facilities was at 42.0%, in FY 11-12 it was at 41.1%, and in FY 12-13 it was at 42.1%.

As a percentage of consumers served, Older Adults served in Short Doyle/Medi-Cal facilities increased by 1.3% from 5.6% to 6.9% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of Older Adults served in Short Doyle/Medi-Cal facilities was at 6.2%, in FY 11-12 it was at 7.1%, and in FY 12-13 it was at 7.5%.

**TABLE 19: CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE /
MEDI-CAL FACILITIES BY GENDER AND SERVICE AREA
FY 2013 - 2014**

Service Area (SA)	Male	Female	Total
SA1	5,556	6,150	11,706
Percent	47.5%	52.5%	100.0%
SA2	15,051	15,542	30,593
Percent	49.2%	50.8%	100.0%
SA3	13,817	13,258	27,075
Percent	51.0%	49.0%	100.0%
SA4	23,316	19,529	42,845
Percent	54.4%	45.6%	100.0%
SA5	4,843	4,675	9,518
Percent	50.9%	49.1%	100.0%
SA6	16,695	16,803	33,498
Percent	49.8%	50.2%	100.0%
SA7	11,751	12,113	23,864
Percent	49.2%	50.8%	100.0%
SA8	17,719	18,237	35,956
Percent	49.3%	50.7%	100.0%
Total	98,373	97,629	196,002
Percent	50.2%	49.8%	100.0%

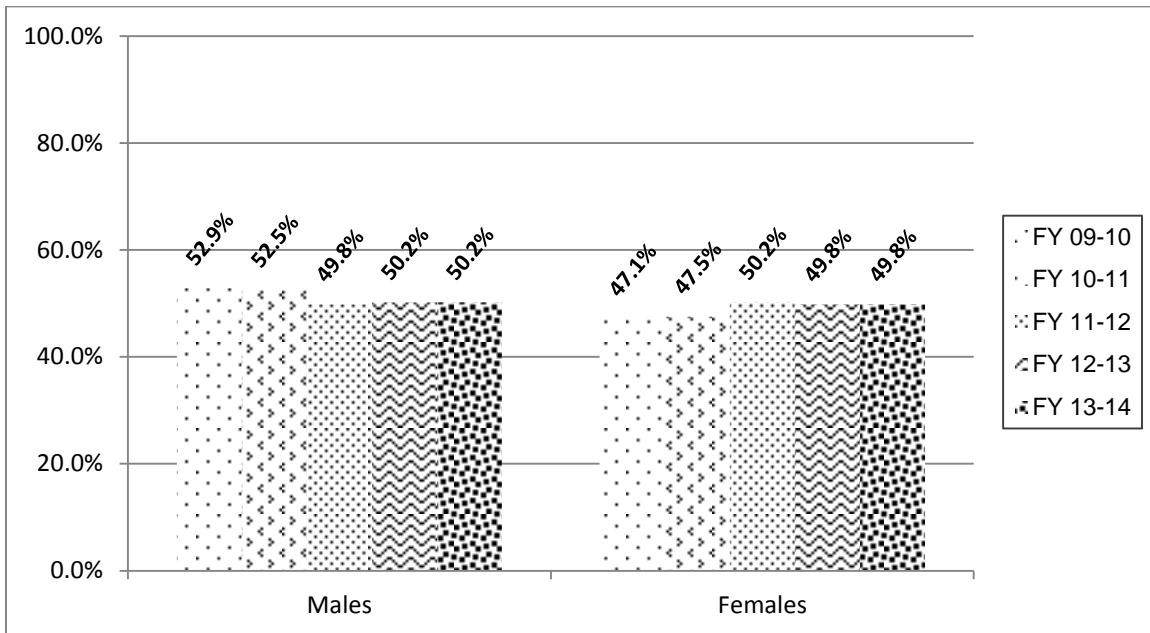
Note: Bold represent highest and lowest percent within each gender across Service Areas. Excludes consumers not reporting their gender, (N = 2,268). Total reflects unduplicated count of consumers served. Some consumers (N = 19,053) were served in more than one SA or 215,055 duplicated count. Data Source: LACDMH-IS Database, October 2014.

Differences by Gender

SA 4 at 54.4% has the highest percentage of males served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 1 at 47.5%.

SA 1 at 52.5% has the highest percentage of females served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 4 at 45.6%.

**FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY GENDER
FY 2009 – 2010 TO FY 2013 – 2014**



Data Source: LACDMH-IS Database, October 2014.

As a percentage of consumers served, males served in Short Doyle/Medi-Cal facilities decreased by 2.7% from 52.9% to 50.2% between FY 09-10 and FY 13-14. In FY 10-11 the percent of males served in Short Doyle/Medi-Cal facilities was at 52.5%, in FY 11-12 it was at 49.8%, and in FY 12-13 it was at 50.2%.

As a percentage of consumers served, females served in Short Doyle/Medi-Cal facilities increased by 2.7% from 47.1% to 49.8% between FY 09-10 and FY 13-14. In FY 10-11 the percentage of females served in Short Doyle/Medi-Cal facilities was at 47.5%, in FY 11-12 it was at 50.2%, and in FY 12-13 it was at 49.8%.

**TABLE 20: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT
SHORT DOYLE/MEDI-CAL FACILITIES BY THRESHOLD LANGUAGE
FY 2013 – 2014**

Service Area (SA)	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA1	1	3	1	10,452	1	1	7	1	1	1,149	4	2	11,623
Percent	0.0%	0.0%	0.0%	89.9%	0.0%	0.0%	0.1%	0.0%	0.0%	9.9%	0.0%	0.0%	100.0%
SA2	1,021	20	14	20,917	283	69	22	19	86	6,866	105	63	29,485
Percent	3.5%	0.1%	0.0%	70.9%	1.0%	0.2%	0.1%	0.1%	0.3%	23.3%	0.4%	0.2%	100.0%
SA3	34	23	379	19,291	4	40	292	97	2	5,125	46	270	25,603
Percent	0.1%	0.1%	1.5%	75.3%	0.0%	0.2%	1.1%	0.4%	0.0%	20.0%	0.2%	1.1%	100.0%
SA4	233	151	134	27,849	75	722	97	38	94	8,240	123	157	37,913
Percent	0.6%	0.4%	0.4%	73.5%	0.2%	1.9%	0.3%	0.1%	0.2%	21.7%	0.3%	0.4%	100.0%
SA5	2	1	1	7,167	35	11	6	2	14	878	5	0	8,122
Percent	0.0%	0.0%	0.0%	88.2%	0.4%	0.1%	0.1%	0.0%	0.2%	10.8%	0.1%	0.0%	100.0%
SA6	4	3	9	22,507	3	58	14	4	4	7,044	9	14	29,673
Percent	0.0%	0.0%	0.0%	75.9%	0.0%	0.2%	0.0%	0.0%	0.0%	23.7%	0.0%	0.0%	100.0%
SA7	4	54	3	14,506	0	49	40	4	1	5,763	26	6	20,456
Percent	0.0%	0.3%	0.0%	70.9%	0.0%	0.2%	0.2%	0.0%	0.0%	28.2%	0.1%	0.0%	100.0%
SA8	10	709	9	22,806	3	99	32	20	3	5,431	94	223	29,439
Percent	0.0%	2.4%	0.0%	77.5%	0.0%	0.3%	0.1%	0.1%	0.0%	18.4%	0.3%	0.8%	100.0%
Total	1,309	964	550	145,495	404	1,049	510	185	205	40,496	412	735	192,314
Percent	0.7%	0.5%	0.3%	75.7%	0.2%	0.5%	0.3%	0.1%	0.1%	21.1%	0.2%	0.4%	100.0%

Note: SA Threshold Languages are in bold. 3,092 consumers served in Short Doyle/Medi-Cal (SD/MC) facilities reported "Other" as their primary language. 525 consumers served in SD/MC facilities reported their primary language as "Unknown" or were "Missing" in the IS database. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level and is not reported in the Table by Service Area: N = 71 (0.04%). Data Source: LACDMH-IS Database, October 2014.

Table 20 shows the primary language of consumers served by threshold language. Below is a discussion of the threshold languages by Service Area for groups that constitute at least 1% of consumers in their Service Area.

SA 1: 10,452 (89.9%) English speaking consumers were served; and 1,149 (9.9%) Spanish speaking consumers were served.

SA 2: 1,021 (3.5%) Armenian speaking consumers were served; 20,917 (70.9%) English speaking consumers were served; 283 (1%) Farsi speaking consumers were served; 86 (0.3%) Russian speaking consumers were served; 6,866 (23.3%) Spanish speaking consumers were served; and 105 (0.4%) Tagalog speaking consumers were served.

SA 3: 379 (1.5%) Cantonese speaking consumers were served; 19,291 (75.3%) English speaking consumers were served; 292 (1.1%) Mandarin speaking consumers were served; 5,125 (20%) Spanish speaking consumers were served; and 270 (1.1%) Vietnamese speaking consumers were served.

SA 4: 233 (0.6%) Armenian speaking consumers were served; 134 (0.4%) Cantonese speaking consumers were served; 27,849 (73.5%) English speaking consumers were served; 722 (1.9%) Korean speaking consumers were served; 94 (0.2%) Russian speaking consumers were served; 8,240 (21.7%) Spanish speaking consumers were served; 123 (0.3%) Tagalog speaking consumers were served.

SA 5: 7,167 (88.2%) English speaking consumers were served; 35 (0.4%) Farsi speaking consumers were served; and 878 (10.8%) Spanish speaking consumers were served.

SA 6: 22,507 (75.9%) English speaking consumers were served; and 7,044 (23.7%) Spanish speaking consumers were served.

SA 7: 1414,506 (70.9%) English speaking consumers were served; and 5,763 (28.2%) Spanish speaking consumers were served.

SA 8: 709 (2.4%) Cambodian speaking consumers were served; 22,806 (77.5%) English speaking consumers were served; 5,431 (18.4%) Spanish speaking consumers were served.

SECTION 3

QI WORK PLAN EVALUATION REPORT FOR CY 2014

LACDMH provides a full array of treatment services as required under Welfare and Institutions Code (W&IC) Sections 5600.3, State Medi-Cal Oversight Review Protocol. The QI Work Plan Goals are in place to monitor and evaluate the quality of the service delivery system. In accordance with the Mental Health Plan reporting requirements of the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning Quality Improvement, the LACDMH evaluation of Quality Improvement activities are structured and organized according to the following domains:

1. Monitoring Service Delivery Capacity
2. Monitoring Accessibility of Services
3. Monitoring Beneficiary Satisfaction
4. Monitoring Clinical Care
5. Monitoring Continuity of Care
6. Monitoring Provider Appeals

The QI Work Plan Goals for 2014 focus on monitoring access to services for target populations, service delivery capacity, timeliness of the services provided, language needs of consumers, consumer satisfaction with the services received, the quality of services provided, and other areas of quality improvement as identified by the LACDMH.

The following Section 3 provides an evaluation summary on the progress made by LACDMH in reaching each goal.

QUALITY IMPROVEMENT WORK PLAN EVALUATION SUMMARY - CY 2014

I. MONITORING SERVICE DELIVERY CAPACITY

1. 49% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 13-14. **Goal met.**
2. 47% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 13-14. **Goal met.**
3. Increase the number of consumers receiving mental health services through tele-psychiatry appointments by 50% in Calendar Year 2014 compared to Calendar Year 2013. **Goal partially met, with a 32% increase from CY 2013.**

II. MONITORING ACCESSIBILITY OF SERVICES

1. Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 72%. **Goal met.**
2. Seventy-five percent of calls to the toll free hotline are answered by a live agent within a minute from when they present to the Virtual Call Center (VCC) of the toll free hotline. **Goal was not met.**
3. Maintain percent of completed test calls to the toll free hotline at 95% in CY 2014. **Goal exceeded at 98%.**
4. Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations at 85.7% in CY 2014. **Goal met.**
5. Maintain the percent of consumers/families reporting that they are able to receive services at convenient times at 91.0% in CY 2014. **Goal met.**
6. 100 clergy who serve underserved populations (Latino & Asian) will have received at least 5 of the courses of the Clergy Academy curriculum by Dec. 31, 2014. **Goal exceeded, with 217 clergy trained.**

III. MONITORING BENEFICIARY SATISFACTION

1. Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background at 89% in CY 2014. **Goal met.**
2. Maintain the percent of all age group consumers/families reporting overall satisfaction with services provided at 83% in CY 2014 and continue year to year trending of the data. **Goal exceeded at 85%.**
3. Monitor the grievances, appeals and requests for State Fair Hearings for FY 2013-2014. Resolve all standard appeals within 45 days of receipt of appeal by Patients' Rights Office. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log. **Goal met.**
4. Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their change of provider requests. Maintain a rate of 94% of providers reporting the requests for change of provider for the CY 2014. **Goal met.**

IV. MONITORING CLINICAL CARE

1. Continue to improve medication practices through systematic use of medication parameters, medication peer review, and trainings for the use of medication. **Goal met.**

V. MONITORING CONTINUITY OF CARE

1. 10% of clients enrolled in the FSP pilot integration project will transition to a lower level of care in Calendar Year 2014. **Goal exceeded, with 17% transitioning to lower level of care.**

VI. MONITORING OF PROVIDER APPEALS

1. The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal. **Goal met.**

I. MONITORING SERVICE DELIVERY CAPACITY

Goal I.1

49% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 13-14.

Penetration Rate Numerator: Unduplicated number of consumers served by ethnicity during the fiscal year in SD / Medi-Cal outpatient and day treatment facilities.

Penetration Rate Denominator: Total County population living at or below 138% FPL estimated with SED and SMI.

Prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS). The CHIS rates are estimated from a random sample of surveys of the population of the County of Los Angeles. The CHIS collects survey data on mental health utilization patterns from the population of the County of Los Angeles every two years within each Service Area and by the ethnicity. This allows for more precise estimates of prevalence and provides the ability to conduct trend analysis.

EVALUATION

This goal was met with 50.04% of Latinos estimated with SED and SMI at or below the 138% FPL served. Table 21A below shows the penetration rates for FY12-13 and FY 13-14, using prevalence estimates from CHIS.

Goal I.2

47% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 13-14.

Penetration Rate Numerator: Unduplicated number of consumers served by ethnicity during the fiscal year in SD / Medi-Cal outpatient and day treatment facilities.

Penetration Rate Denominator: Total County population living at or below 138% FPL estimated with SED and SMI.

Prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS). The CHIS rates are estimated from a random sample of surveys of the population of the County of Los Angeles. The CHIS collects survey data on mental health utilization patterns from the population of the County of Los Angeles every two years within each Service Area and by the ethnicity. This allows for more precise estimates of prevalence and provides the ability to conduct trend analysis.

EVALUATION

This goal was met with 47.46% of Asians with SED and SMI at or below the 138% FPL served. Table 21A below shows the penetration rates for FY12-13 and FY 13-14, using prevalence estimates from CHIS.

**TABLE 21A: TWO YEAR TREND IN PENETRATION RATE BY ETHNICITY
FOR POPULATION LIVING AT OR BELOW 138% FPL BASED ON
PREVALENCE RATE FROM CHIS¹
FY 12-13 TO FY 13-14**

Ethnicity	FY 12-13	FY 13-14
African American	111.15%	112.89%
Consumers Served	49,087	47,343
Estimated population with SED/SMI	44,161	41,939
Asian/Pacific Islander	47.13%	47.46%
Consumers Served	9,227	9,117
Estimated population with SED/SMI	19,578	19,208
Latino	49.59%	50.04%
Consumers Served	101,353	102,640
Estimated population with SED/SMI	204,379	205,131
Native American	82.49%	103.56%
Consumers Served	1,102	1,192
Estimated population with SED/SMI	1,336	1,151
White	84.71%	82.40%
Consumers Served	37,166	35,710
Estimated population with SED/SMI	43,872	43,337
Total	63.17%	63.07%
Consumers Served	197,935	196,002
Estimated population with SED/SMI	313,326	310,767

Notes: Ethnic specific Prevalence Rate for SED for Youth and SMI for Adults from ¹ 2011-2012 California Health Interview Survey (CHIS) were applied to calculate Penetration Rate. Data Source: LACDMH-IS Database, October 2014.

**TABLE 21B: PENETRATION RATE AMONG TOTAL POPULATION AND
POPULATION LIVING AT OR BELOW 138% FPL
BY ETHNICITY AND SERVICE AREA
FY 2013 - 2014**

Ethnicity and Service Area	Number of Consumers Served¹	Total Population Estimated with SED and SMI	Penetration Rates for Total Population²	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level²
SA 1					
African American	4,297	4,882	88.0%	4,451	96.5%
Asian/Pacific Islander	120	1,067	11.2%	137	87.6%
Latino	4,120	15,014	27.4%	7,377	55.8%
Native American	77	310	24.8%	111	69.4%
White	3,092	10,526	29.4%	2,354	131.4%
Total	11,706	31,800	36.8%	14,430	81.1%
SA 2					
African American	3,307	5,999	55.1%	2,663	124.2%
Asian/Pacific Islander	1,118	17,315	6.5%	2,115	52.9%
Latino	16,423	74,364	22.1%	35,626	46.1%
Native American	131	768	17.1%	150	87.3%
White	9,614	75,246	12.8%	15,569	61.8%
Total	30,593	173,692	17.6%	56,124	54.5%
SA 3					
African American	3,221	5,136	62.7%	2,229	144.5%
Asian/Pacific Islander	2,187	35,110	6.2%	7,097	30.8%
Latino	17,264	70,452	24.5%	25,747	67.1%
Native American	121	592	20.4%	108	112.0%
White	4,282	29,323	14.6%	4,957	86.4%
Total	27,075	140,613	19.3%	40,137	67.5%
SA 4					
African American	10,862	4,773	227.6%	3,211	338.3%
Asian/Pacific Islander	2,790	14,154	19.7%	3,959	70.5%
Latino	21,811	50,612	43.1%	32,796	66.5%
Native American	374	414	90.3%	211	177.3%
White	7,008	21,850	32.1%	6,542	107.1%
Total	42,845	91,804	46.7%	46,719	91.7%
SA 5					
African American	2,540	2,923	86.9%	1,166	217.8%
Asian/Pacific Islander	245	6,229	3.9%	1,270	19.3%
Latino	3,019	8,834	34.2%	3,353	90.0%
Native American	48	189	25.4%	24	200.0%
White	3,666	31,961	11.5%	5,756	63.7%
Total	9,518	50,137	19.0%	11,570	82.3%

**TABLE 21B (CONTD.): PENETRATION RATE AMONG TOTAL POPULATION
AND POPULATION LIVING AT OR BELOW 138% FPL
BY ETHNICITY AND SERVICE AREA
FY 2013 - 2014**

Ethnicity and Service Area	Number of Consumers Served¹	Total Population Estimated with SED and SMI	Penetration Rates for Total Population²	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level²
SA 6					
African American	16,570	22,338	74.2%	16,987	97.5%
Asian/Pacific Islander	310	1,319	23.5%	675	45.9%
Latino	15,473	59,778	25.9%	38,771	39.9%
Native American	55	289	19.0%	198	27.8%
White	1,090	1,969	55.4%	895	121.8%
Total	33,498	85,692	39.1%	57,526	58.2%
SA 7					
African American	1,819	3,067	59.3%	1,165	156.1%
Asian/Pacific Islander	574	8,320	6.9%	969	59.2%
Latino	18,292	82,824	22.1%	33,344	54.9%
Native American	384	535	71.8%	134	286.6%
White	2,795	14,328	19.5%	2,392	116.8%
Total	23,864	109,074	21.9%	38,004	62.8%
SA 8					
African American	11,104	17,890	62.1%	10,068	110.3%
Asian/Pacific Islander	2,286	17,247	13.3%	2,985	76.6%
Latino	15,391	53,305	28.9%	28,117	54.7%
Native American	138	703	19.6%	215	64.2%
White	7,037	34,453	20.4%	4,872	144.4%
Total	35,956	123,597	29.1%	46,257	77.7%

**TABLE 21B (CONTD.): PENETRATION RATE AMONG TOTAL POPULATION
AND POPULATION LIVING AT OR BELOW 138% FPL BY ETHNICITY AND
SERVICE AREA
FY 2013 – 2014**

Ethnicity and Service Area	Number of Consumers Served¹	Total Population Estimated with SED and SMI	Penetration Rates for Total Population²	Population Living at or Below 138% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living at or Below 138% Federal Poverty Level²
Unduplicated Consumers Served in At least 1 Service Area					
African American	47,343	67,009	70.7%	41,939	112.9%
Asian/Pacific Islander	9,117	100,761	9.0%	19,208	47.5%
Latino	102,640	415,182	24.7%	205,131	50.0%
Native American	1,192	3,801	31.4%	1,151	103.6%
White	35,710	219,656	16.3%	43,337	82.4%
Total	196,002	806,409	24.3%	310,767	63.1%
Duplicated Countywide Consumers Served in More Than one Service Area					
		Percent			
African American	6,377	13.5%			
Asian/Pacific Islander	513	5.6%			
Latino	9,153	8.9%			
Native American	136	11.4%			
White	2,874	8.0%			
Total	19,053	9.7%			

Data Source: Prevalence Rate by ethnicity from 2011 - 2012 California Health Interview Survey (CHIS). Note: ¹ Number of Consumers Served represents consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. The count does not include consumers served by Fee-For Service Outpatient & Inpatient Providers, County Hospitals and consumers served in jails and juvenile halls. ² Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI. In some Service Areas, Penetration Rates for some ethnic groups exceed 100% because of small distribution of that population in that Service Area.

**TABLE 22: ESTIMATED PREVALANCE RATES FOR SED & SMI BY
CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS) WITH CONFIDENCE
INTERVALS: 2009 AND 2011-2012**

	Total Population			
	2009	Confidence Interval	2011	Confidence Interval
Total	7.3%	(6.0-8.6)	8.0%	(7.1-8.9)
African American	14.6*	(5.2-24.1)	7.8%	(5.0-10.6)
API	6.1%	(3.7-8.4)	6.9%	(4.4-9.4)
Latino	7.3%	(5.5-9.1)	8.6%	(7.2-10.0)
Native American	.025*	(0.0-7.3)	19.4*	(1.6-37.2)
White	6.1%	(4.5-7.7)	7.7%	(6.2-9.3)
Two or More Races	.056*	(1.3-9.9)	6.9%*	(0.7-13.1)

	Population at or Below 138% FPL			
	2009	Confidence Interval	2011	Confidence Interval
Total	8.8%	(6.1 - 11.6)	11.4%	(9.5 - 13.3)
African American	29.3%*	(4.8 - 53.8)	15.8%	(9.0 - 22.6)
API	7.6%*	(2.3 - 13.0)	7.3%	(3.1 - 11.5)
Latino	7.0%	(5.1 - 8.9)	11.4%	(9.0 - 13.8)
Native American	-	-	24.0%*	(0.0 - 63.2)
White	8.2%	(4.7 - 11.6)	11.0%	(5.8 - 16.2)
Two or More Races	7.4%*	(0.0 - 17.9)	14.8%*	(0.0 - 37.7)
	Population at or Below 200% FPL			
	2009	Confidence Interval	2011	Confidence Interval
Total	9.7%	(7.2-12.2)	10.7%	(9.1-12.3)
African American	26.4%*	(7.6-45.3)	14.0%	(8.6-19.5)
API	6.1%*	(2.2-10.1)	5.3%	(2.4-8.2)
Latino	8.2%	(6.0-10.4)	10.6%	(8.6-12.6)
Native American	9.2%*	(0.0-27.0)	19%*	(0.0-40.7)
White	9.7%	(5.8-13.6)	13.0%	(8.1-17.8)
Two or More Races	7.4%*	(0.0-16.6)	14.1%*	(0.0-32.1)

Note: * = Statistically Unreliable. Data Source: California Health Interview Survey (CHIS), 2011 -2013.

Goal I.3.

Increase the number of consumers receiving mental health services through tele-psychiatry appointments by 50% in Calendar Year 2014 compared to Calendar Year 2013.

EVALUATION

In CY 2014, 512 consumers were served through tele-psychiatry appointments. This represents a 32% increase over the 388 clients served in 2013, falling short of the 50% goal. Staffing issues related to the departure of a psychiatrist in September 2014 led to a decrease in the number of clients receiving tele-psychiatry appointments in the last quarter of CY 2014. A new psychiatrist was hired in November 2014; however, initial training and orientation and access to LACDMH tele-psychiatry information systems and technology has delayed tele-psychiatry appointments with this psychiatrist. There will be an increase in tele-psychiatry appointments starting early January in CY 2015.

II. MONITORING ACCESSIBILITY OF SERVICES

Goal II.1.

Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 72%.

Numerator: The number of after-hours PMRT responses with a response time of one hour or less.

Denominator: Total number of after-hours PMRT responses.

EVALUATION

This goal has been met.

**TABLE 23: PSYCHIATRIC MOBILE RESPONSE TEAM (PMRT) AFTER-HOURS RESPONSE RATES OF ONE HOUR OR LESS
CY 2010 – 2014**

Month	2010	2011	2012	2013	2014
January	67%	76%	69%	75%	75%
February	65%	72%	64%	68%	73%
March	63%	71%	66%	68%	73%
April	65%	69%	61%	72%	72%
May	63%	74%	66%	71%	71%
June	68%	68%	65%	71%	73%
July	71%	71%	70%	71%	74%
August	75%	67%	70%	71%	76%
September	74%	68%	65%	74%	73%
October	71%	68%	67%	75%	74%
November	70%	66%	70%	73%	67%
December	71%	68%	N/A ¹	74%	73%
Annual Total	3,857	4,288	3,984	4,859	5,824
Annual Average %	69%	70%	67%	72%	73%

Note: ¹December 2012 data is not available due to transition to the new phone monitoring system on November 27, 2012.

Table 24 shows that in 2014, an average of 73% of PMRT calls resulted in mobile teams being present at the scene within one hour or less from acknowledgement of receipt of the call. This reflects a 1% increase over the previous year performance of 72%.

Trending analysis during a five (5) year period, from 2010 to 2014, shows an increase in the annual total number of after-hours PMRT responses to calls in

one hour or less. The total number of after-hours PMRT responses to calls in one hour or less in 2010 were 3,857; in 2011 there were 4,288; in 2012 there were 3,984; in 2013 there were 4,859; and in 2014 there were 5,824.

LACDMH utilizes the ACCESS Center PMRT responsiveness as an indicator of timeliness of field visits requiring rapid intervention and assistance. The rationale for this indicator concerns providing alternatives to hospitalization and linkage with other appropriate levels of care such as Urgent Care Centers.

ACCESS Center Response Time

Goal II.2.

Seventy-five percent of calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline.

Numerator: Total number of calls in which caller reached a live agent within 1 minute.

Denominator: Total number of calls to the ACCESS Center.

**TABLE 24: CALLS ANSWERED WITHIN 1 MINUTE BY NUMBER AND PERCENT
CY 2014**

Month	Total # of Calls to the NIVR ¹	Total # of Calls Extended to Agents	Total # of Calls That Were Answered Within 1 Minute	Percentage of Calls in Queue That Were Answered Within 1 Minute
January	20,925	15,645	8,838	56%
February	19,289	14,162	8,773	62%
March	21,068	15,764	9,876	63%
April	19,214	14,442	10,772	75%
May	21,232	15,835	11,243	71%
June	19,295	14,529	10,473	72%
July	19,091	14,391	11,312	79%
August	19,873	14,821	10,597	71%
September	20,986	15,630	8,901	57%
October	22,317	17,506	9,206	53%
November	18,620	13,612	8,189	60%
December	18,147	13,644	9,059	66%
Total	240,057	179,981	117,239	65%

Data Source: LACDMH ACCESS Center, CY 2014.

¹ Total calls to the Network Interactive Voice Response (NIVR) includes all calls to the public and the provider lines.

EVALUATION

This goal has not been met, with an annual average of 65% of calls having been answered within one minute. The 75% goal was reached in the months of April and July. Several factors have led to inability to reach this goal and to the drop-off in response time over the last few months of 2014. First, the ACCESS Center has experienced a number of staff departures (6) in CY 2014 which has negatively impacted staffing resources required to respond to calls in a timely manner. When those positions are filled, response time is expected to improve. The ACCESS Center is actively involved in recruiting staff to fill these vacancies. Additionally, beginning in January 2014, the Appointment Line began operating during normal business hours. This is a service provided to Managed Care Plans to assist beneficiaries who need an urgent appointment for Specialty Mental Health Services assessment in five (5) business days. Two staff items were approved for this new service, but up to five staff items were needed to handle the call volume. This necessitated taking the additional staff items from handling the beneficiary calls on the toll-free line. Beginning in August 2014, accessing the Integrated Behavioral Health Information System (IBHIS - electronic health record) to determine past history of services and accessing the Service Request Tracking System (SRTS) to transfer the client records electronically to the referred clinic has significantly increased the length of calls related to initial service requests for referrals. This had a significant impact on the annual average for the percentage of calls answered within one (1) minute in CY 2014.

A further review of data on the response times for calls answered within one (1) minute for after-hours and daytime calls showed that the 75% goal was met for after-hours calls but not for daytime calls. The systemic issues potentially have a different impact on daytime versus after-hours calls. The impact of the implementation of SRTS and IBHIS and the related electronic processing of referrals potentially had a greater impact on daytime response times than after-hours response times due to other factors involved such as differences in call volume during daytime versus after-hours. Further, it is anticipated that in March 2015 the ACCESS Center will transition to using IBHIS for processing of all calls and related documentation in the Electronic Health Record. Also, it is anticipated that by the end of the FY 14-15, Workforce Management software will be fully implemented at the ACCESS Center. This will allow a closer evaluation of workgroup activity and the more appropriate allocation of staff based on call volume. Taking into consideration the above systemic issues that are likely to impact the overall response times and the differences in the impact on daytime versus after-hours call response times reflected in the CY 2014 data, the goal related to "calls answered within 1 minute" will be set to a different standard for daytime and after-hours in CY 2015, and the MHP will continue to monitor the response times and address the systemic issues that impact response times for both daytime and after-hours calls.

Background about ACCESS

LACDMH's ACCESS Center provides emergency and non-emergency services. The ACCESS Center strives to meet the cultural and linguistic needs of our communities by providing language assistance services in threshold and non-threshold languages at the time of first contact. Callers request information related to mental health services and other social needs, and the ACCESS Center supplies them with referrals to culture-specific providers and services that are appropriate to their needs and conveniently located.

ACCESS Center Calls Received in Non-English Languages

Non-English speaking and Limited English Proficiency beneficiaries have a right to receive services in their primary or preferred language. LACDMH has 13 threshold languages including: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. When ACCESS Center staff cannot assist callers because of a language barrier, they immediately contact the Language Line for assistance with language interpretation services. The ACCESS Center also provides equitable language assistance services to deaf/hearing impaired consumers and providers requesting American Sign Language (ASL) interpretation services for their consumers.

TABLE 25: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FOUR YEAR TREND - CY 2011 – 2014

Language	2011	2012	2013	2014
AMHARIC	2	2	0	1
*ARABIC	7	4	21	24
*ARMENIAN	35	61	48	225
BENGALI	1	2	1	0
BOSNIAN	0	0	0	1
BULGARIAN	0	0	0	0
BURMESE	0	0	0	0
*CANTONESE	19	7	46	60
CEBUANO	0	0	0	1
*FARSI	46	59	70	81
FRENCH	2	1	1	2
GERMAN	0	0	0	0
HEBREW	0	0	1	2
HINDI	1	5	0	1
HUNGARIAN	0	0	0	0
ITALIAN	0	0	0	0
JAPANESE	6	5	3	2
KHMER	16	35	10	5
*KOREAN	54	83	109	132
KURDISH-BEHDINI	0	0	0	1
LAOTIAN	0	0	0	2
*MANDARIN	52	40	57	30
MONGOLIAN	0	0	1	0
NEPALI	0	0	1	2
OROMO	0	0	0	0
PASHTO	0	0	0	3
POLISH	0	0	0	0
PORTUGUESE	0	0	0	1
PUNJABI	0	0	0	0
SERBIAN	0	0	5	0
ROMANIAN	0	1	0	0
*RUSSIAN	21	26	15	11
SAMOAN	0	0	5	0
SERBIAN	0	0	0	0
*SPANISH (AVAZA Language Services)	4,282	4,552	2,509	1,402
SPANISH ACCESS CTR	4,393	4,043	11,240 ¹	6,135
SPANISH SUB TOTAL	8,675	8,595	13,749	7,537
*TAGALOG	35	14	16	18
THAI	2	1	1	2
TURKISH	0	1	0	0
URDU	1	3	2	1
*VIETNAMESE	15	23	24	24
TOTAL	8,990	8,968	14,184¹	8,169

*LACDMH Threshold Language excluding Other Chinese and English. ¹ The total for non-English calls and Spanish ACCESS Center Calls for CY 2013 is inaccurate and overreported due to errors in the Web Center System. Data Source: LACDMH ACCESS Center, CY 2014.

Table 25 summarizes the total number of calls in 38 non-English languages received by the ACCESS Center for Calendar Years 2011 through 2014. The trending over the last four years indicates that the majority of non-English callers requested language interpretation services in the threshold languages, and mostly in Spanish. Calls received in other languages included Korean, Mandarin, Cantonese, Armenian, Farsi, Vietnamese, and Arabic.

In 2014, the ACCESS Center received 7,537 calls in Spanish or 92.3% of all non-English calls. Spanish is the most common language after English for calls received by the ACCESS Center in 2014. The second most common language for non-English calls received by the ACCESS Center in 2014 was Armenian at 225 calls or 2.8% of all non-English calls. This represented a 450% increase in Armenian calls compared to 2013. The Eastern European/Middle Eastern UREP subcommittee had PSAs in Armenian from August through November 2014 that potentially contributed to the increase in number of calls in Armenian.

As noted under Table 25, the total number of calls in 2013 is inaccurate due to errors in the tracking and reporting of Spanish ACCESS Center Calls and non-English calls by the now-replaced Verizon Web Center application, which was in use from January to October 2013. Beginning in January 2013, the Symposium application was replaced with a web based application called "Web Center". The Web Center application reported incorrect numbers starting from January 2013 through October 2013.

These errors led to an over-reporting of Spanish language calls and explain the significantly higher number of Spanish ACCESS Center calls and total non-English calls received in 2013 when compared to other years. Due to the data reporting errors, the Web Center was quickly replaced with a new web based application called Virtual Call Center (VCC). However, due to the replacement of the Web Center by the new Virtual Call Center (VCC) system in October 2013, the errors stemming from the Web Center application can no longer be corrected. While a potential increase in the Spanish ACCESS Center calls in CY 2013 can be attributed in part to the increase in the number of Spanish speaking ACCESS Center staff, this increase is overreported due to reporting errors from the Web Center system. The Calendar Year (CY) 2014 total is accurate and consistent with the numbers seen in CY 2011 and CY 2012. The number of Spanish-language calls using the AVAZA Language Services line has decreased due to the successful effort of ACCESS Center to hire more Spanish speaking staff. 11 new Spanish speaking employees were hired in 2013, and 12 more were hired in 2014. The ACCESS Center hopes to hire 5 more Spanish speaking employees in 2015.

ACCESS Call Center Test Calls

Goal II.3.

Maintain percent of completed test calls to the toll free hotline at 95% in CY 2014.

EVALUATION

This goal has been met, with the percent of completed calls at 98.1% in CY 2014. Please see the Test Calls Report in Appendix A available at <http://psbqi.dmh.lacounty.gov/QI.htm> for additional information.

Consumer Satisfaction Survey Goals

Goal II.4.

Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations at 85.7% in CY 2014.

EVALUATION

This goal has been met, with 85.9% of consumers/families agreeing or strongly agreeing that the locations of services were convenient for them. This represents a 0.2% increase over the previous year.

**TABLE 26: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY
AGREE OR AGREE WITH “LOCATION OF SERVICES WAS CONVENIENT
FOR ME”
BY AGE GROUP**

AGE GROUP	FY 08-09 May 2009	FY 11-12 Feb 2012	FY 12-13 Aug 2012	FY 13-14 Aug 2013	FY 13-14 April 2014
YSS-F					
Number	6,889	9,920	3,384	2,898	2,797
Percent	93.3%	93.7%	91.0%	91.5%	90.9%
YSS					
Number	4,577	5,974	1,727	1,371	1,166
Percent	82.9%	81.0%	80.6%	82.1%	82.9%
Adult					
Number	5,559	9,855	3,244	4,431	2,907
Percent	84.6%	84.7%	82.0%	83.0%	82.6%
Older Adult					
Number	615	1,211	292	267	268
Percent	90.0%	82.4%	87.7%	87.6%	88.4%
Total					
Number	17,640	26,960	8,647	8,967	7,138
Percent	87.7%	87.1%	85.5%	85.7%	85.9%

Notes: YSS-F = survey for families of children 0-12 years old; YSS = survey for youth 12-17 years old. Number of Responses is the number of surveys responding to the survey item on a Likert scale from 1 to 5. This was the effective denominator in all fiscal years. Per CDMH Memo June 14, 2010, Consumer Satisfaction Survey data collection was suspended for CY 2010.

Table 26 shows the percent of consumers and families that agree or strongly agree they received services at convenient locations for five (5) distinct survey periods, from May 2009 to April 2014. For YSS-F, the percent has decreased from 93.3% in May 2009 to 90.9% in April 2014. For YSS, the percent in May 2009 matched the percent in April 2014, at 82.9%, and increased by 0.8% from August 2013. For Adults, the percent has decreased from 84.6% in May of 2009 to 82.6% in April 2014. For Older Adults, the percent has decreased from 90.0% in May of 2009 to 88.4% in April 2014.

The April 2014 percentage represents a 0.8% improvement over the previous year. The overall gain in improvement between FY 12-13 and FY 13-14 is partly due to the weighted contribution of YSS-F surveys to the overall rate of improvement. Beginning in FY 2012-13, LACDMH began collecting survey data from a random sample of providers which dropped the number of surveys returned from approximately 26,960 in FY 11-12 to approximately 12,000 in FY 12-13. In addition YSS-F surveys remained the highest percent of surveys returned as compared with any other age group. YSS-F surveys also reported the highest percent that “Strongly Agreed” or “Agreed” with the Convenience of Location of Services, thereby contributing to overall improvement in this measure over the last three survey periods from FY 12-13 to FY 13-14.

Goal II.5.

Maintain the percent of consumers/families reporting that they are able to receive services at convenient times at 91.0% in CY 2014.

EVALUATION

This goal has been met, with 91.2% on consumers/families agreeing or strongly agreeing that they were able to receive services at convenient times. This represents a 0.2% increase from August 2013.

TABLE 27: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH “SERVICES WERE AVAILABLE AT TIMES THAT WERE GOOD FOR ME” BY AGE GROUP

AGE GROUP	FY 08-09 May 2009	FY 11-12 Feb 2012	FY 12-13 Aug 2012	FY 13-14 Aug 2013	FY 13-14 April 2014
YSS-F					
Number	6,889	9,920	3,375	2,908	6,715
Percent	94.1%	94.2%	93.2%	93.4%	94.0%
YSS					
Number	4,577	5,974	1,735	1,367	1,152
Percent	81.7%	81.7%	80.6%	85.4%	81.9%
Adult					
Number	5,559	9,855	3,261	4,449	3,143
Percent	89.7%	89.5%	89.0%	91.3%	89.1%
Older Adult					
Number	615	1,211	295	283	285
Percent	93.4%	93.2%	95.3%	91.2%	94.4%
Total					
Number	17,640	26,960	8,666	9,007	11,295
Percent	89.7%	89.7%	89.2%	91.0%	91.2%

Notes: YSS-F = survey for families of children 0-12 years old; YSS = survey for youth 12-17 years old. Number of Responses is the number of surveys responding to the survey item on a Likert scale from 1 to 5. This was the effective denominator in all fiscal years. Per CDMH Memo June 14, 2010, Consumer Satisfaction Survey data collection was suspended for CY 2010.

Table 27 shows the percent of consumers and families that agree or strongly agree that services were available at times that were convenient for them for five (5) distinct survey periods, from May 2009 to April 2014. For YSS-F, the percent has increased from 93.4% in August 2013 to 94.0% in April 2014. For YSS, the percent has decreased from 85.4% in August 2013 to 81.9% in April 2014. For Adults, the percent decreased from 91.3% in August 2013 to 89.1% in April 2014. For Older Adults, the percent increased from 91.2% in August 2013 to 94.4% in April 2014. Overall, for all age groups the percent increased from 89.7% in May 2009 to 91.2% in April 2014.

Goal II.6.

100 clergy who serve underserved populations (Latino & Asian) will have received at least 5 of the courses of the Clergy Academy curriculum by Dec. 31, 2014.

EVALUATION

This goal has been met. A total of 217 clergy (147 Latino and 77 Asian) received at least 5 courses from the academy, thus increasing their knowledge and skills on mental health-related issues.

III. MONITORING BENEFICIARY SATISFACTION

Goal III.1.

Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background at 89% in CY 2014.

EVALUATION

This goal has been met, with 89.8% of consumers/families agreeing or strongly agreeing that staff was sensitive to their cultural/ethnic background. This represents a 0.6% increase from August 2013.

TABLE 28: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH “STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND” BY AGE GROUP

AGE GROUP	FY 08-09 May 2009	FY 11-12 Feb 2012	FY 12-13 Aug 2012	FY 13-14 Aug 2013	FY 13-14 April 2014
YSS-F					
Number	6,889	9,920	3,087	2,669	6,665
Percent	95.5%	91.1%	94.8%	95.1%	93.4%
YSS					
Number	4,577	5,974	1,627	1,229	1,122
Percent	84.6%	76.8%	82.7%	87.6%	84.6%
Adult					
Number	5,559	9,855	3,126	4,254	2,864
Percent	84.6%	86.0%	85.1%	85.8%	84.3%
Older Adult					
Number	615	1,211	278	266	262
Percent	91.2%	90.8%	90.3%	91.0%	90.3%
Total					
Number	17,640	26,960	8,118	8,418	10,913
Percent	89.0%	86.1%	88.5%	89.2%	89.8%

Notes: YSS-F = survey for families of children 0-12 years old; YSS = survey for youth 12-17 years old. Number of Responses is the number of surveys responding to the survey item on a Likert scale from 1 to 5. This was the effective denominator in all fiscal years. Per CDMH Memo June 14, 2010, Consumer Satisfaction Survey data collection was suspended for CY 2010.

Table 28 shows the percent of consumers and families that agree or strongly agree that staff were sensitive to their cultural background for five (5) distinct survey periods, from May 2009 to April 2014. For YSS-F, the percent decreased from 95.5% in May 2009 to 93.4% in April 2014. For YSS, the percent agreeing was 84.6% in both May 2009 and April 2014. For Adults, the percent decreased from 84.6% in May 2009 to 84.3% in April 2014. For Older Adults, the percent decreased from 91.2% in May 2009 to 90.3% in April 2014. Overall, for all age groups the percent increased from 89.2% in August 2013 to 89.8% in April 2014. The overall percentage increased from FY 13-14 in spite of lower percentages

across all respondent groups because the group reporting the highest level of agreement (YSS-F) made up a greater percentage of respondents than in FY 13-14; thus those respondents had a larger impact on the overall percentage.

Goal III.2.

Maintain the percent of all age group consumers/families reporting overall satisfaction with services provided at 83% in CY 2014 and continue year-to-year trending of the data.

EVALUATION

This goal was exceeded, with 85% of consumers/families reporting overall satisfaction with services.

Goal III.3.

Monitor the grievances, appeals and requests for State Fair Hearings for FY 2013-2014. Resolve all standard appeals within 45 days of receipt of appeal by Patients' Rights Office. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log.

EVALUATION

This goal has been met, with 100% of standard appeals resolved within 45 days, and 100% of grievances were resolved within 60 days.

The Quality Improvement Division is responsible for conducting the annual evaluation of beneficiary grievances, appeals, and fair hearings. (State Department of Health Care Services, Program Oversight and Compliance, 2012-2013)

The MHP shall insure that a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Council, the MHP's administration or another appropriate body within the MHP. (State Department of Health Care Services, Program Oversight and Compliance, 2012-2013)

**TABLE 29: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS
FY2011-2012 TO FY 2013-2014**

CATEGORY	FY 11 - 12	FY 12 -13	FY 13 -14
	Inpatient/Outpatient	Inpatient/Outpatient	Inpatient/Outpatient
ACCESS	21	0	28
Percent	100.00%	0.0%	100.0%
TERMINATION OF SERVICES	1	8	N/A
Percent	100.00%	100.00%	N/A
DENIED SERVICES (NOA - A Assessment)	0	5	5
Percent	0.00%	100.0%	100.0%
CHANGE OF PROVIDER	10	5	3
Percent	100.00%	100.0%	100.0%
QUALITY OF CARE			
Provider Relations	305	317	200
Percent	52.00%	64.2%	52.8%
Medication	86	95	38
Percent	14.70%	19.2%	10.0%
Discharge/Transfer	24	22	6
Percent	4.10%	4.5%	1.6%
Patient's Rights Materials	12	2	0
Percent	2.00%	0.4%	0.0%
Treatment Concerns	24	8	64
Percent	4.10%	1.6%	16.9%
Abuse - Physical	32	26	40
Percent	5%	5.3%	10.6%
Abuse - Sexual	8	4	6
Percent	1.37%	0.8%	1.6%
Abuse Verbal	12	5	14
Percent	2.05%	1.0%	3.7%
Abuse (Total)	52	35	60
Percent	100.00%	7.1%	15.8%
Delayed Services	4	0	1
Percent	1.90%	0.0%	0.3%
Seclusion and Restraint	11	14	4
Percent	1.90%	2.8%	1.1%
Quality of Care	13	1	6
Percent	2.20%	0.2%	1.6%
Reduction of Services	3	0	0
Percent	0.50%	0.0%	0.0%
Sub-Total for Quality of Care	534	494	379
Percent	100.00%	100.0%	100.0%

**TABLE 29 (CONTD.): INPATIENT AND OUTPATIENT GRIEVANCES AND
APPEALS
FY2011-2012 TO FY 2013-2014**

CATEGORY	FY 11 - 12	FY 12 -13	FY 13 -14
CONFIDENTIALITY	10	6	4
Percent	100.00%	100.0%	100.0%
OTHER			
Access to Personal Belongings	1	0	1
Percent	1.10%	0.0%	2.0%
Housing Concerns	17	13	11
Percent	19.10%	15.3%	22.0%
Legal Concerns	11	0	3
Percent	12.40%	0.0%	6.0%
Lost/Stolen Belongings	11	17	10
Percent	12.40%	20.0%	20.0%
Money/Funding/Billing	10	10	5
Percent	11.20%	11.8%	10.0%
Non HIPAA Concerns	2	2	NA
Percent	2.20%	2.4%	NA
Non Provider Concerns	3	15	3
Percent	3.40%	17.6%	6.0%
Phone	6	5	1
Percent	6.70%	5.9%	2.0%
Smoking	7	6	NA
Percent	7.90%	7.10%	NA
Visitors	1	4	1
Percent	1.10%	4.7%	2.0%
Miscellaneous	13	6	10
Percent	14.60%	7.1%	20.0%
Clothing	5	4	2
Percent	0.20%	4.7%	4.0%
Forms		N/A	1
Percent		N/A	2.0%
Letter Writing Material	N/A	N/A	1
Percent	N/A	N/A	2.0%
Other	2	N/A	2
Percent	2.20%	N/A	0.4%
Sub-Total	89	85	50
Percent	100.00%	100.0%	100.0%
Total	665	603	469
Percent	100.00%	100.00%	100.0%

Note: Shaded cells without numerical values indicate that data is not available for the fiscal year. Data Source: LACDMH Patients' Rights Office, CY 2014.

Table 29 shows that the total number of inpatient and outpatient grievances and appeals decreased by 23% from 603 in FY 12-13 to 469 in FY 13-14. The majority of inpatient and outpatient grievances and appeals were for Quality of Care for both FY 12-13 (82%) and FY 13-14 (81%).

**TABLE 30: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS BY
LEVEL AND DISPOSITION
FY 2013-2014**

CATEGORY	LEVEL				
	Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited State Fair Hearing
ACCESS	5	4	0	19	0
Percent	1.1%	100.0%	0.0%	100.0%	0.0%
TERMINATION OF SERVICES	No Data	No Data	No Data	No Data	No Data
Percent					
DENIED SERVICES (NOA - A Assessment	5	0	0	0	0
Percent	1.1%	0.0%	0.0%	0.0%	0.0%
CHANGE OF PROVIDER	3	0	0	0	0
Percent	0.7%	0.0%	0.0%	0.0%	0.0%
QUALITY OF CARE	379	0	0	0	0
Percent	85.0%	0.0%	0.0%	0.0%	0.0%
CONFIDENTIALITY	4	0	0	0	0
Percent	0.9%	0.0%	0.0%	0.0%	0.0%
OTHER	50	0	0	0	0
Percent	11.2%	0.0%	0.0%	0.0%	0.0%
Total	446	4	0	19	0
Percent	100.0%	100.0%	0.0%	100.0%	0.0%

CATEGORY	DISPOSITION		
	Referred Out	Resolved	Still Pending
ACCESS	0	28	0
Percent	0.0%	6.2%	0.0%
TERMINATION OF SERVICES	No Data	No Data	No Data
Percent			
DENIED SERVICES (NOA - A Assessment	0	5	0
Percent	0.0%	1.1%	0.0%
CHANGE OF PROVIDER	0	3	0
Percent	0.0%	0.7%	0.0%
QUALITY OF CARE	9	370	0
Percent	50.0%	82.0%	0.0%
CONFIDENTIALITY	2	2	0
Percent	11.1%	0.4%	0.0%
OTHER	7	43	0
Percent	38.9%	9.5%	0.0%
Total	18	451	0
Percent	100.0%	100.0%	0.0%

Data Source: Patients' Rights Office, CY 2014.

Table 30 shows that among the inpatient and outpatient grievances and appeals in FY 13-14 there were 446 grievances, 4 appeals, and 19 requests for State Fair Hearings. Table 30 also shows that by disposition among these grievances and appeals, 18 were referred out, 451 were resolved, and none were reported as still pending.

Goal III.4.

Monitor Beneficiary Requests for Change of Provider, including reasons given by consumers for their change of provider requests. Maintain a rate of 94% of providers reporting the requests for change of provider for the CY 2014.

EVALUATION

This goal has been met, with 95.1% of providers reporting the requests for change of provider for the CY 2014. The total number of recorded Requests for Change of Provider increased by 42% from 2,187 in FY 12-13 to 3,101 in FY 13-14.

QID has acquired Teleform software to improve data accuracy and processing of data entry forms. This software will potentially be used to convert manual data entry forms to electronic forms in order to improve timeliness of reporting of Change of Provider Request Logs from providers and quarterly reporting of these measures.

**TABLE 31: REQUEST FOR CHANGE OF PROVIDER BY REASONS
AND PERCENT APPROVED
FY 2012 – 2013 TO FY 2013 – 2014**

	FY 2012 - 2013			FY 2013 - 2014		
Reason¹	Number of Requests	Percent Approved	Rank Order	Number of Requests	Percent Approved	Rank Order
Not A Good Match	320	91.25%	1	452	83.63%	1
Uncomfortable	255	89.02%	2	371	80.32%	2
Other	193	89.12%	3	278	82.37%	3
Does Not Understand Me	168	87.50%	4	254	76.38%	4
Treatment Concerns	221	91.86%	5	251	82.47%	5
Insensitive/Unsympathetic	155	87.10%	6	225	76.00%	6
Lack of Assistance	157	89.17%	7	238	80.67%	7
Medication Concerns	121	85.95%	8	191	80.10%	8
No Reason Given	108	87.96%	9	183	82.51%	9
Gender	109	89.91%	10	114	89.47%	10
Not Professional	112	84.82%	11	111	81.98%	11
Language	75	93.33%	12	89	85.39%	13
Time/Schedule	43	81.40%	13	88	76.14%	14
Want Previous Provider	62	90.32%	14	101	89.11%	12
Want 2 nd Opinion	45	75.56%	15	77	80.52%	15
Age	28	85.71%	16	57	77.19%	16
Treating Family Member	15	93.33%	17	21	85.71%	17
Total	2,187			3,101		

Data Source: Patients' Rights Office, CY 2014. ¹ Multiple reasons may be given by a consumer.

Table 31 shows the number of Requests for Change of Provider by reasons, percent, and rank order according to frequency for FY 12-13 and FY 13-14. Data for the requests for Change of Provider are based on information from forms which agencies are required to submit on a monthly basis to the Patients' Rights Office (PRO).

IV. MONITORING CLINICAL CARE

Goal IV.1.

Continue to improve medication practices through systematic use of medication parameters, medication peer review, and trainings for the use of medications.

EVALUATION

This goal has been met.

During 2014, LACDMH reviewed and revised a number of policies and parameters regarding medications through the work of an internal group and in consultation with an outside expert group. In June 2014, the following parameters were revised:

- Parameter 3.6 Use of Psychoactive Medications in Dual Diagnosis Clients
- Parameter 3.10 Use of Medication Assisted Treatment (MAT) in Individuals with Co-Occurring Substance Abuse Disorders

In October 2014, the following parameters were revised:

- Parameter 3.2 Use of Antidepressant Medications
- Parameter 3.3 Use of Antipsychotic Medications
- Parameter 3.4 Use of Anxiolytic Medications
- Parameter 3.5 Use of Mood-Stabilizing Medications
- Parameter 3.7 Parameters for General Health Monitoring

In December of 2014, the following parameter was revised:

- Parameter 3.8 Use of Psychotropic Medication in Children and Adolescents

These updated parameters have been made available on the DMH website at http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_practice.

During 2014, the LACDMH Office of the Medical Director conducted a Peer Review to examine compliance with annual documentation of Body Mass Index (BMI) for patients receiving antipsychotic medication outlined in DMH 3.7 Parameters for General Health Monitoring, as well as documentation on the Outpatient Medication Review (OMR) form that demonstrates the psychiatrist reviewed the current dosages, side effects, and when to take medications with the patient within past 12 months (as required in DMH Policy 103.1 Standards for Prescribing and Furnishing Psychoactive Medications). Five (5) charts of patients prescribed an antipsychotic from each psychiatrist were used as the sample, with a total of 978 charts sampled (a 622% increase in sample size from 2012). 34% of charts sampled included a BMI calculation within the past 12

months. 74% of sampled charts included current medications on the OMR (a 10% increase from 2012), with 71% of sampled charts having an OMR dated within the past 12 months (a 7% increase from 2012). Regional Medical Directors/Supervising Psychiatrists have apprised prescribers of the requirements regarding BMI and OMR documentation and referred them to the appropriate policies.

During 2014, ten trainings were sponsored by the Department regarding medication practices, attended by 223 physicians.

V. MONITORING CONTINUITY OF CARE

Goal V.1.

10% of clients enrolled in the FSP pilot integration project will transition to a lower level of care in Calendar Year 2014.

EVALUATION

This goal has been met. Out of 1,141 clients enrolled, 194 clients (17%) disenrolled from the pilot from January – November, 2014, due to successfully meeting their goals. Those clients either transitioned out of the system or to lower levels of care.

VI. MONITORING PROVIDER APPEALS

Goal VI.1.

The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal.

EVALUATION

This goal has been met, with 100% of provider appeals having been responded to within 60 calendar days.

**TABLE 32: PROVIDER APPEALS
CY 2014**

Appeals	Day Treatment	Network Inpatient	Network Outpatient
Total	0	1,310	8
Approved	0	367	3
Denied	0	943	5
Pending	0	0	0

There were a greater number of appeals from inpatient providers (1,310) compared to outpatient providers (8). Twenty-Eight percent (28%) of the inpatient provider appeals were approved and 72% of the appeals were denied. In contrast, a larger percentage of appeals from outpatient providers were approved (37.5%), with 62.5% denied. There were no appeals from day treatment providers for CY 2014.

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: At least 50% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 14-15

Population: Latino population estimated with SED and SMI and living at or below 138% FPL

Indicator: Latino consumers receiving outpatient services in LACDMH SD/MC facilities

Measure: Unduplicated number of Latino consumers served in LACDMH SD/MC outpatient facilities / By Latino population estimated with SED and SMI and living at or below 138% FPL multiplied by 100

Source(s) of Information:

1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS)
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau

Responsible Entity: PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 2: At least 47% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 14-15.

Population: API population estimated with SED and SMI and living at or below 138% FPL

Indicator: API consumers receiving outpatient services in LACDMH SD/MC facilities

Measure: Unduplicated number of API consumers served in LACDMH SD/MC outpatient facilities / By API population estimated with SED and SMI and living at or below 138% FPL multiplied by 100

Source(s) of Information:

1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS)
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau

Responsible
Entity: PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 3: Maintain the number of clients served by tele-psychiatry in CY 2015 at the same capacity as in CY 2014 (N=512)

Population: Consumers receiving mental health services through tele-psychiatry at various end points in Los Angeles County Department of Mental Health (LACDMH) Directly Operated Clinics of the Department of Mental Health

Indicator: Service delivery capacity for psychiatry appointments via tele-psychiatry

Measure: Number of consumers receiving mental health services through tele-psychiatry appointments in CY 2015 compared to CY 2014

Source(s) of Information/: LACDMH IS approved claims data

Responsible Entity: Office of the Medical Director (OMD), PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 1: Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 73%

Population: Consumers receiving urgent after-hour care from Psychiatric Mobile Response Teams (PMRT) of the Los Angeles County Department of Mental Health (LACDMH) Emergency Outreach Bureau (EOB)

Indicator: Timeliness of after-hour care

Measure: The number of after-hour PMRT responses with response times of one hour or less / the total number of after-hours PMRT responses for the Calendar Year 2015 multiplied by 100

Source(s) of Information: ACCESS Center Data

Responsible Entity: EOB, ACCESS Center, PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 2a: **Seventy-five percent of after-hours calls to the toll-free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.**

GOAL 2b: **Sixty Percent of daytime calls to the toll-free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll-free hotline.**

Population: Callers using the ACCESS 24/7 Toll Free number:
1-800-854-7771

Indicator: Timeliness of the MHP's toll free hotline

Measure: 2a. The number of after-hours calls for the Calendar Year 2014 that are answered within one minute from when they present to the Virtual Call Center (VCC) / the total number of after-hours calls extended to the VCC for the Calendar Year 2014 multiplied by 100.

2b. The number of daytime calls for the Calendar Year 2014 that are answered within one minute from when they present to the Virtual Call Center (VCC) / the total number of daytime calls extended to the VCC for the Calendar Year 2014 multiplied by 100.

Source(s) of Information: ACCESS Center Data

Responsible Entity: ACCESS Center, PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 3: Maintain percent of completed test calls to the toll free hotline at 98% in CY 2015

Population: Test Callers using the 24/7 Toll Free number: 1-800-854-7771

Indicator: Percent of Test Calls completed

Measure: Number of Test Calls completed / total number of test calls multiplied by 100

Source(s) of
Information: Service Area Quality Improvement Committee (SA QIC) Test Calls

Responsible
Entity: ACCESS Center, SA QICs, PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 4: Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations at 86% in CY 2015

Population: Consumers served in SD / MC Outpatient and Day Treatment Facilities

Indicator: Convenience of service locations

Measure: The number of consumers/families that agree or strongly agree on the MHSIP survey that they are able to receive services at convenient locations / By the total number of consumers/families completed the survey during the survey period multiplied by 100

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Responsible Entity: PSB-QID, Los Angeles County Department of Mental Health (LACDMH) Outpatient and Day Treatment Providers

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 5: Maintain the percent of consumers/families reporting that they are able to receive services at convenient times at 91.2% in CY 2015

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Convenience of appointment times

Measure: The number of consumers/family members that agree or strongly agree on the MHSIP survey that they are able to receive services at convenient times / By the total number of consumers/family members that completed the survey during the survey period multiplied by 100

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP)
Consumer Survey

Responsible Entity: PSB-QID, Los Angeles County Department of Mental Health
Outpatient and Day treatment Providers

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 1: Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background at 89.8% in CY 2015

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Sensitivity of staff to consumers' cultural/ethnic backgrounds

Measure: The number of consumers/family members that agree or strongly agree that staff is sensitive to their cultural/ethnic background / By the total number of consumers/family members that completed the survey during the survey period multiplied by 100

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP)
Consumer Survey

Responsible Entity: Quality Improvement Division, Data-GIS Unit, Los Angeles County Department of Mental Health Outpatient and Day treatment Providers

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 2: Maintain the percent of consumers/families reporting overall satisfaction with services provided at 85% in CY 2015 and continue year to year trending of the data

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Overall satisfaction with services provided

Measure: The number of consumers/families that agree or strongly agree they are satisfied overall with the services they have received / By the total number of consumers/families that completed the survey during the survey period multiplied by 100

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Responsible Entity: PSB-QID, Los Angeles County Department of Mental Health (LACDMH) Outpatient and Day treatment Providers

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 3: a. Monitor the grievances, appeals and requests for State Fair Hearings for FY 2014-2015

b. Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office.

c. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log

Population: Consumers/families served by Los Angeles County Department of Mental Health

Indicator: Resolution of beneficiary grievances, appeals, and requested State Fair Hearings

Measure: Number and type of the beneficiary grievances, appeals, and State Fair Hearings resolved and referred out, and pending for FY 2014-2015

Source(s) of Information: Patients' Rights Office (PRO) Data Reports

Responsible Entity: Patients' Rights Office (PRO), PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 4: Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests

Ninety-Five percent of providers will report the consumers' requests for change of provider in at least 11 of 12 months in CY 2015

Population: Consumers and their families served by Los Angeles County Department of Mental Health

Indicator: Number and type of Requests for Change of Provider

Measure: Number of providers reporting consumers' requests for change of provider in at least 11 of 12 months/ By the number of providers required to report their requests for change of provider to Patients' Rights Office (PRO) multiplied by 100

Source(s) of Information: Patients' Rights Office (PRO) Data Reports

Responsible Entity: Patients' Rights Office (PRO), PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 5: Implement the revised peer survey in CY 2015

Population: Consumers/families receiving mental health services at LACDMH Directly Operated and Contracted Programs

Indicator: Consumer/family perception of satisfaction

Measure: Revised peer survey developed by the Office of Consumer and Family Affairs in collaboration with the Quality Improvement Division in response to feedback provided by Service Area Administration to the CY 2014 peer survey and inclusive of family member input

Source(s) of Information: Revised peer survey on tele-form and summary reports of survey results for CY 2015 peer survey

Responsible Entity: Office of Consumer and Family Affairs, Office of the Director and PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 1: Continue to improve medication practices through systematic use of medication parameters, peer review related to medication practices, and trainings for the use of medication.

Population: Consumers receiving medication support services

Indicator: Prescribing standards and parameters

Measure: Review and update of medication parameters, medication-related trainings, and reports of peer review related to medication practices

Source(s) of Information: Office of the Medical Director (OMD) Reports

Responsible Entity: Office of the Medical Director (OMD), PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 2: Implement the Spiritual Self-Care Facilitator training at Wellness Centers in LACDMH Directly Operated Programs in CY 2015 to facilitate Spirituality Self-Care Groups with consumers at these Centers

Population: Consumers receiving mental health services at Wellness Centers in LACDMH Directly Operated Programs

Indicator: Impact of Spiritual Self-Care in Recovery and Wellness

Measure: Implementation of the Spiritual Self-Care Facilitator training at Wellness Centers in LACDMH Directly Operated Programs in CY 2015 and review of training evaluations and outcomes related to this training

Source(s) of Information/: Reports on the implementation and evaluation of the Spiritual Self-Care Facilitator training and outcomes related to the Spirituality Self-Care Group participants

Responsible Entity: Community and Government Relations Division (CGRD), Office of the Director and PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 3: Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online revised COD 101 training targeting all LACDMH Directly Operated and Contracted Adult System of Care (ASOC) programs in Calendar Year 2015

Population: Consumers receiving COD treatment services

Indicator: COD Training Protocols and Procedures to improve clinical care related to COD treatment

Measure: Review, update, and provision of COD 101 ASOC on-site training and online training accessible to all LACDMH Directly Operated and Contracted programs; total number of clinicians who completed the revised on-site/online training in CY 2015, and training evaluation summaries completed for these trainings

Source(s) of
Information: Office of the Medical Director (OMD) Reports

Responsible
Entity: Office of the Medical Director (OMD), PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN V: MONITORING CONTINUITY OF CARE

GOAL 1: 90% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days

Population: Consumers referred for urgent appointments by the Medi-Cal Managed Care Plans

Indicator: Continuity of Care for consumers referred for specialty mental health services by primary care providers and behavioral health network providers of the Medi-Cal Managed Care Plans

Measure: $\frac{\text{Number of Urgent Appointments received within five (5) business days from the date referred by the Medi-Cal Managed Care Plans to the Urgent Appointment Line for Calendar Year 2015}}{\text{Total Number of Urgent Appointment Referrals received from the Medi-Cal Managed Care Plans to the Urgent Appointment Line for the Calendar Year 2015}} \times 100$

Source(s) of Information: ACCESS Center, Health Care Reform Operations Bureau, Special Projects Unit

Responsible Entity: ACCESS Center, Health Care Reform Operations Bureau, Special Projects Unit, PSB-QID

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION**

QI WORK PLAN GOALS - CY 2015

DOMAIN VI: MONITORING PROVIDER APPEALS

GOAL 1: The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal

Population: Contracted Providers

Indicator: Timeliness of the MHP's written response to Provider Appeals

Measure: Number of MHP's responses to Provider Appeals (day treatment, inpatient, and outpatient) within 60 calendar days for Calendar Year 2015 / By the total number of provider appeals for Calendar Year 2015 multiplied by 100

Source(s) of
Information: Los Angeles County Department of Mental Health (LACDMH)
Managed Care Division and Provider Support Organization (PSO)

Responsible
Entity: Managed Care Division, PSO, PSB-QID

QUALITY IMPROVEMENT WORK PLAN - CY 2015

I. MONITORING SERVICE DELIVERY CAPACITY

1. At least 50% of Latinos estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 14-15
2. At least 47% of Asian Pacific Islanders (API) estimated with SED and SMI at or below the 138% Federal Poverty Level (FPL) will be served in LACDMH Short Doyle/Medi-Cal (SD/MC) facilities in FY 14-15
3. Maintain the number of clients served by tele-psychiatry in CY 2015 at the same capacity as in CY 2014 (N=512)

II. MONITORING ACCESSIBILITY OF SERVICES

1. Maintain the percentage of after-hours PMRT responses with a response time of one hour or less at 73%
- 2a. Seventy-five Percent of after-hours calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline
- 2b. Sixty percent of daytime calls to the toll free hotline are answered by a live agent within 1 minute from when they present to the Virtual Call Center (VCC) of the toll free hotline
3. Maintain percent of completed test calls to the toll free hotline at 98% in CY 2015
4. Maintain the percent of consumers/families reporting that they are able to receive services at convenient locations at 88% in CY 2015
5. Maintain the percent of consumers/families reporting that they are able to receive services at convenient times at 91.2% in CY 2015

III. MONITORING BENEFICIARY SATISFACTION

1. Maintain the percent of consumers/families reporting that staff was sensitive to their cultural/ethnic background at 89.8% in CY 2015
2. Maintain the percent of consumers/families reporting overall satisfaction with services provided at 85% in CY 2015 and continue year-to-year trending of the data
3. Monitor the grievances, appeals and requests for State Fair Hearings for FY 2014-2015. Resolve all standard appeals within 45 calendar days of receipt of appeal by Patients' Rights Office. Resolve all grievances within 60 calendar days from the date the grievance was logged on the Problem Resolution Log
4. Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their change of provider requests. Ninety-five percent of providers will report the requests for change of provider in at least 11 of 12 months in CY 2015
5. Implement the revised peer survey in CY 2015

IV. MONITORING CLINICAL CARE

1. Continue to improve medication practices through systematic use of medication parameters, peer review related to medication practices, and trainings for the use of medication
2. Implement the Spiritual Self-Care Facilitator training at Wellness Centers in LACDMH Directly Operated Programs in CY 2015 to facilitate Spirituality Self-Care groups with consumers at these Centers
3. Continue to improve Clinical Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders (COD) through on-site and online revised COD 101 training targeting all LACDMH Directly Operated and Contracted Adult System of Care (ASOC) programs in Calendar Year 2015

V. MONITORING CONTINUITY OF CARE

1. 90% of the consumers referred for urgent appointments by the Medi-Cal Managed Care Plans to the Urgent Appointment Line at the ACCESS Center will receive appointments for a Specialty Mental Health Service Assessment within 5 business days

VI. MONITORING OF PROVIDER APPEALS

1. The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal